Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL21399038M
Compliance #: HL21399039C

Date Concluded: May 17, 2021

Name, Address, and County of Licensee Investigated:
The Prairie Lodge Senior Living
6001 Earle Brown Drive
Brooklyn Center, MN 55430
Hennepin County

Facility Type: Home Care Provider

Investigator's Name:
Lori Pokela, RN
Special Investigator
Paul Spencer, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):
It is alleged: The facility neglected the client when the facility failed to ensure adequate fluid intake resulting in dehydration. Additionally, the facility neglected the client when the facility failed to ensure adequate skin care resulting in skin breakdown.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility neglected the client when the facility failed to assess the client's declining condition. The client's decline included an infected and worsening pressure injury with pain, which led to sepsis (total body infection), dehydration, and hospitalization with surgical intervention.

The investigation included interviews with staff members, including administrative staff, nursing staff, on-call nursing staff, and unlicensed staff. The investigation included an interview with a member of the client's family. The investigation included a review of the client's facility medical record and hospital records. The investigation included a review of the facility's shift communication notes used for shift-to-shift communication, on-call nurse phone logs and relevant policies and procedures.

The client's diagnoses included dementia and diabetes. The client's service plan indicated the client required assistance of one staff to walk, a gait belt for transferring or a mechanical lift as needed. The same document indicated the client required assistance with incontinence cares and repositioning while in bed. The client's nursing assessment indicated the client was forgetful and confused. The same document indicated the client had a stage 2 (a shallow open area) pressure injury on her coccyx (tailbone). The client's medical record indicated she had a pending wound care nurse consultation.

The client's progress notes and shift communication notes were reviewed. On a Saturday, unlicensed personnel (ULP)-M wrote the client cried for one and a half hours during the night shift. ULP-F wrote the client was weak and laid in bed during the dayshift. At 10:08 a.m., RN-I documented she received a phone call from ULP- to report the client had wound pain. The same document indicated RN-I directed the ULPs to continue with acetaminophen (pain medication), barrier cream to pressure injury, and reposition the client every two hours. At 12:17 p.m. a different he on-call RN-J, documented she received a phone call on Saturday afternoon regarding the client by an outside agency nurse. RN-J documented the client's O2 saturations were low, in the upper 80 percent, but the client was not short of breath. RN-J did not document specific interventions for the ULPs to continue monitoring. ULP-K wrote the client had a severe sore on tail bone and was "not doing good" during the evening shift.

On Sunday, ULP-M wrote the client was not doing well during the night and advised staff to check on her. ULP-F wrote the client was struggling with eating, was still in pain, had an elevated respiratory rate of 22 respirations per minute and ULP-F updated RN-I during the dayshift. ULP-K wrote the client's wound was getting worse, the wound smelled badly, and the client was not eating during the evening shift. The client's record lacked nursing progress notes or assessments on Sunday.

On Monday, the clinical director (CD), who is a RN, assessed the client and found her with weakness, low levels of oxygen saturation in the upper 80 percent, and a worsening coccyx wound. The client transferred to the hospital.

The client's hospital records were reviewed. The client admitted on Monday with dehydration and sepsis related to the client's wound infection and required intravenous (IV) fluids and antibiotics. The hospital records included an image, which depicted the clients wound with open and blackened areas. The client's wound was unstageable (unable to visualize base of wound) and covered with necrotic (dead tissue), which required surgical debridement to

remove the dead tissue. After discharge, the client admitted to another facility and did not return to the home care provider.

During an interview, the CD stated she observed the client on the previous Friday up in a chair and comfortable. The CD stated the ULPs working Monday morning found the client had difficulty eating and could not get out of bed. The CD stated when she assessed the client on Monday, she found the client limp and too sick to lift her head. The CD stated the client's pressure injury had worsened and covered with black tissue, so she sent the client to the hospital. The CD stated she reviewed the shift communication notes she found ULP-F wrote she contacted the on-call nurse on Sunday, but there was no follow-up documented in the client's medical record. The CD stated she thought the client did not eat or drink over the weekend because the staff interpreted her behavior as a refusal to raise

During an interview, ULP-F, who worked both day Saturday and Sunday day shifts, stated when she saw the client's wound on Saturday it was "dark" and draining "pus". ULP-F stated the client was in pain and could not sit up by herself, so she contacted RN-I, who was on-call. ULP-F stated she had a hard time recalling Sunday, but she thought the client was about the same. ULP-F stated the client could not sit up to eat or drink so ULP-F swabbed her mouth with water. Upon reviewing the shift communication notes for Sunday day shift, ULP-F acknowledged she called RN-I, but did not recall the conversation or any specific direction from RN-I.

During an interview, RN-I, who was on-call both Saturday and Sunday, stated she was working at the time the ULP-F called on Sunday, but she did not recall the phone call. While reviewing the client's medical record for Sunday, RN-I stated there was no follow-up documentation in the client's medical record regarding a call to the on-call nurse this day

During an interview, ULP-K, who worked the evening shift Saturday and Sunday, stated there is no nurse onsite on the weekends but there is an on-call nurse. ULP-K stated sometimes she tries to reach the on-call nurse but is not successful. The ULP-K stated if she cannot reach the nurse, and it is not an emergency, she uses her own discretion and observes the client. ULP-K stated she was not able to reach a nurse that weekend, but she only got a "beeping" sound on the line and it did not allow her to leave a voicemail, so she wrote in the shift communication notes for the next shift to keep an eye on the client. After reviewing the shift communication notes, which indicated the previous shift contacted the on-call nurse, ULP-K stated she did not receive a phone call from the on-call nurse that Sunday.

In conclusion, neglect was substantiated.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Vulnerable Adult interviewed: No; unable to interview due to cognitive impairment.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility conducted an internal investigation the same day the client was sent to the hospital. Education for all nursing staff completed by CD includes staff training on when to call the on-call nurse, repositioning, and incontinence care to prevent skin breakdown.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

Or call: 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding.

cc:
The Office of the Ombudsman for Long-Term Care
Brooklyn Center Attorney
Hennepin County Attorney
Brooklyn Center Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21399	A. BUILDING: _____ B. WING _____	C 01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRAIRIE LODGE AT EARLE BROWN	6001 EARLE BROWN DRIVE BROOKLYN CENTER, MN 55430

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0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On January 26, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL21399038M/#HL21399039C and #HL21399040C. At the time of the survey, there were #18 clients receiving services under the comprehensive license. For complaint #HL21399040C, no correction orders are issued. The following correction orders are issued for #HL21399039C/#HL21399038M, tag identification 0325, tag 0860, and tag 1045.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2).	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who	0 325		

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0 325	Continued From page 1 receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 was neglected. Findings include: On May 17,2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the licensee was responsible for the maltreatment, in connection with incidents which occurred. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No plan of correction is required for tag 0325. Please refer to public maltreatment report for details.	
0 860 SS=G	144A.4791, Subd. 8 Comprehensive Assessment and Monitoring Subd. 8.Comprehensive assessment, monitoring, and reassessment. (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional.	0 860		

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0 860	Continued From page 2 This initial assessment must be completed within five days after the date that home care services are first provided. (b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after the date that home care services are first provided. (c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to monitor and reassess one of one clients (C1) reviewed when her pressure injury worsened and C1 had a change in condition. C1's pressure injury became infected and C1's oxygen levels dropped below normal which led to hospitalization, sepsis (total body infection), dehydration, and surgical intervention. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	0 860		

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0 860	Continued From page 3 C1's medical record was reviewed. C1's diagnoses included dementia and diabetes. C1's Service Plan dated November 10, 2020, indicated C1required assistance with incontinence care. C1's Service Plan dated November 21, 2020 indicated C1 required assistance with repositioning.C1's service plan dated December 8, 2020, indicated C1 transferred with assist of two staff members and to use a mechanical lift if unable to support her weight. C1's nursing assessment dated December 8, 2020, indicated C1 was forgetful and confused due to impaired cognition. The same document indicated C1 had a stage two (a shallow open area) pressure injury on the coccyx. C1's progress notes dated December 10, 2020 at 12:30 p.m., indicated C1's stage two pressure injury had no depth and licensee staff applied barrier cream. The same document indicated a wound care nurse consult was pending. C1's progress notes dated December 12, 2020 at 10:08 a.m., indicated unlicensed personnel (ULP)-F contacted the on-call registered nurse (RN)-I to report C1 had wound pain. The same document indicated RN-I directed the ULPs to continue with acetaminophen (pain medication), barrier cream to pressure injury, and reposition C1 every two hours. C1's progress notes dated December 12, 2020, 12:17 p.m., indicated a wound care nurse from an outside agency, contacted a different on-call nurse, RN-J, to report on C1's oxygen saturation in the upper 80 percentiles. The same document indicated C1's lung sounds were clear with no shortness of breath (SOB)and "refusing" to elevate her head.	0 860		

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0 860	Continued From page 4 C1's record lacked documentation RN-J implemented any continued monitoring measures of C1's condition. The 24-hour report log dated December 12, 2020, a document to communicate between shifts, indicated ULP-M wrote C1 cried for one and a half hours during the night shift. The same document indicated ULP-F wrote C1 was weak and laid in bed during the day shift. The same document indicated ULP-K wrote C1 had a "severe" sore on her tail bone and "not doing good" during the evening shift. The 24-hour report log dated December 13, 2020, indicated ULP-M wrote C1 was not doing well during the night shift and advised staff check on her. The same document indicated ULP-F wrote C1 struggled with eating, was "still" in pain, had a respiration rate of 22, and ULP-F updated RN-I during the day shift. The same document indicated ULP-K wrote C1's wound was getting worse, smelt badly, and C1 was not eating during the evening shift. A review of the licensee's 24-hour report log for December 13, 2020, lack indication ULP-K (evening shift) or ULP-M (night shift) tried to contact the on-call nurse regarding C1. C1's nursing assessment completed by the clinical director (CD-E) who is an RN, and dated December 14, 2020, indicated C1 had a black pressure injury to coccyx (tailbone). C1's progress notes dated December 14, 2020 at 1:50 p.m., signed by CD-E, indicated C1's wound had become wider, and more reddened. This same document indicated C1 was lethargic and	0 860		

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0 860	Continued From page 5 weak with an oxygen saturation at 87-88%. This same document indicated C1 transferred to the hospital. C1's hospital progress noted dated December 14, 2020, indicated C1's admitting diagnoses included dehydration requiring intravenous (IV) fluids and sepsis caused by a wound infection requiring IV antibiotics. The same document indicated the pressure injury had multiple areas of deep tissue damage. C1's hospital records dated December 14, 2020, included an image of C1's pressure injury. The image showed a coccyx wound with open and blackened areas. C1's hospital progress notes for December 17, 2020 at 9:19 a.m., indicated C1's coccyx wound required surgical debridement to remove necrotic (black, dead) tissue surrounding the ulceration. C1's physician progress noted December 18, 2020 at 9:29 a.m., indicated C1's impaired cognition increased her risk for dehydration, which was worsened by C1's pressure injury infection and sepsis. During an interview on February 10, 2021, at 10:00 a.m., ULP-F stated she notified the on-call nurse, RN-I, and reported C1's wound pain on December 12, 2020. ULP-F stated RN-I directed to continue with acetaminophen. After reviewing the 24-hour report for December 13, 2020, ULP-F stated she called RN-I but did not remember the conversation. During this same interview ULP-F stated C1's wound was "dark" and draining "pus". During an interview on February 12, 2020, at 10:10 a.m., ULP-K, who worked the evening shift	0 860		

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0 860	Continued From page 6 December 12, 2020 and December 13, 2020, stated there is no nurse onsite on the weekends but there is an on-call nurse. ULP-K stated sometimes she tries to reach the on-call nurse but is not successful. The ULP-K stated if she cannot reach the nurse, and it is not an emergency, she uses her own discretion and observes the client. ULP-K stated she did not reach the on-call nurse that weekend but instead only got a "beeping" sound on the line and could not leave a voicemail, so she wrote in the 24-hour report log for the next shift to keep an eye on the client. During the same interview ULP-K stated C1 had a wound with a black center on the coccyx area. The licensee provided the on-call telephone logs from December 13, 2020. The telephone logs indicated a call from ULP-F's cell phone number to the on-call nurse phone number and forwarded to RN-I's work phone number lasting 1 minute, and 28 seconds occurred on December 13, 2020 at 7:31 a.m. During an interview on January 26, 2020, at 5:07 p.m., CD-E stated on December 14, 2020, she found C1 in bed, unable to lift her off her pillow and described C1 as "limp". CD-E assessed C1's coccyx area and found the pressure injury to have areas of blackened tissue and 911 was called to transport resident to the hospital. During the same interview, CD-E stated she conducted an internal investigation into what occurred with C1. CD-E found lack of documentation regarding C1's condition on December 13, 2020. CD-E stated the ULP's working on December 13, 2020 and December 14, 2020, stated that C1 was "refusing" to raise her head off the pillow. CD-E provided education to staff regarding C1 being too sick to raise head off the pillow versus	0 860		

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0 860	Continued From page 7 refusing. CD-E stated the internal investigation also found C1 did not have the prescribed barrier cream applied to pressure injury due to lack of supply. During an interview on February 19, 2021 at 11:00 a.m., RN-I stated she did not recall the phone call or a voicemail message from ULP-F regarding C1. RN-I stated when she receives a call regarding a client concern, she records the phone call in the client's medical record. Upon reviewing C1's notes for December 13, 2020, RN-I stated there was no note regarding a phone call regarding C1. RN-I stated if a staff member leaves a voice message for the on-call nurse, the on-call nurse tries to return the call. RN-I stated if a staff member leaves a message for the nurse but does not hear back, that staff member is expected to try contacting the on-call nurse again. An undated licensee-provided document titled "Home Care RN On-Call Notification Guidelines", listed reasons licensee staff would contact an RN. The reasons included oxygen saturations below 90%, respiratory rate greater than 20 per minute, and complaints of severe pain. The document included the following comment, "When in doubt, call the RN On-Call". A licensee-provided document titled "On-Call Policy", dated May 2015, indicated an RN will be available at all times when staff is providing services to clients to respond to concerns. The same document indicated the process to contact the on-call nurse must be available to all staff. The same document indicated the on-call RN will document conversations and actions taken when on-call in the client's file as soon as possible. The licensee-provided document titled Job	0 860		

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0 860	Continued From page 8 Description: Triage Nurse dated August 16, 2018, indicated the on-call nurse is responsible for providing telephone triage nurse for home care support. The same document indicated the on-call nurse accurately documents symptoms, assessments and conducts follows up on situations representing higher risk. The same document indicated the on-call nurse document in the electronic health records. TIME FOR CORRECTION: Seven (7) days	0 860		
01045 SS=D	144A.4793, Subd. 5 Documentation of Treatment/Therapy Subd. 5.Documentation of administration of treatments and therapies. Each treatment or therapy administered by a comprehensive home care provider must be documented in the client's record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the client's needs. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to document treatment administration for one of three clients (C1) reviewed. Staff failed to document the administration of barrier cream to a pressure injury on C1's coccyx (tailbone) area.	01045		

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01045	Continued From page 9 This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: C1's medical record was reviewed. C1's diagnoses included dementia and diabetes. C1's service plan dated December 8, 2020, indicated C1 transferred with assist of two staff members and to use a mechanical lift if unable to support her weight. C1's nursing assessment dated December 8, 2020, indicated C1 was forgetful and confused due to impaired cognition. The same document indicated C1 had stage two pressure injury on the coccyx. C1's physician orders dated December 8, 2020, indicated barrier cream to be applied as needed. C1's progress notes dated December 8, 2020, at 8:29 a.m., indicated C1's physician ordered barrier cream to be applied with each incontinent change, especially reddened or open areas. The 24-hour report log dated December 12, 2020, indicated on dayshift C1's barrier cream was applied. C1's progress notes dated December 12, 2020, 10:08 a.m. indicated a was call made to the on-call nurse who gave a nursing order to turn and reposition C1 every two hours to alleviate pressure on the pressure injury and apply barrier	01045		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21399	A. BUILDING: _____ B. WING _____	C 01/26/2021

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01045	Continued From page 10 cream to C1's pressure injury. C1's progress notes did not include documentation indicating the nursing order was implemented and the nursing order was not included in C1's orders. C1's medication administration record (MAR) dated December 2020, included an order for barrier cream as need. C1's MAR lacked documentation regarding application of C1's barrier cream from the dates of December 8, 2020 to December 14, 2020. C1's service check-off list dated December 2020, indicated C1 received scheduled incontinence cares on December 8, 2020 through December 14, 2020, at 4:00 a.m., 7:00 a.m., 9:00 a.m., 11:00 a.m., 12:00 p.m., 3:00 p.m., 5:00 p.m., 8:00 p.m., and 11:00 p.m. During an interview on January 26, 2021 at 5:27 p.m., the clinical director (CD)-E, stated the barrier cream that was ordered to be used as needed (PRN) was not documented in C1's MAR after unlicensed personnel (ULPs) applied it to C1. During this same interview CD-E stated an empty tube of barrier cream was found by C1's bedside table. The licensee provided a delegation of nursing tasks, treatment or therapy task policy dated February 18, 2019. This document indicated the RN may delegate nursing tasks to ULPs who have successfully completed training, have been trained in the services to be provided and have demonstrated ability to competently follow the procedures for the client and possess the knowledge and skills consistant with the complexity of the tasks.	01045		

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01045	Continued From page 11 TIME FOR CORRECTION: seven (7) days	01045		