

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL240531401M  
**Compliance #:** HL240538953C

**Date Concluded:** June 13, 2024

## **Name, Address, and County of Licensee**

### **Investigated:**

Ability Holdings Prairie Meadows  
800 5<sup>th</sup> Avenue SW  
Kasson, MN 55944  
Dodge County

**Facility Type:** Assisted Living Facility with  
Dementia Care (ALFDC)

**Evaluator's Name:** Danyell Eccleston, RN  
Special Investigator

**Finding:** Not Substantiated

### **Nature of Investigation:**

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.

### **Initial Investigation Allegation(s):**

The facility neglected the resident when safety interventions failed to be implemented while the resident was unsteady and under the influence of alcohol. The resident was found on the floor with a cut to her head and went to the hospital for treatment.

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was not substantiated. The resident experienced falls possibly related to her state during alcohol use, however, the facility contacted nursing staff regarding concerns and implemented hourly safety checks of the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records, hospital records, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed staff providing resident care at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included falls, high blood pressure, and alcohol abuse. The resident's service plan included assistance with medication management and judgment regarding alcohol use. The resident's assessment indicated she was able to walk independently with use of a four wheeled walker and was able to communicate needs.

Progress notes from the time in question indicate a staff member found the resident barefoot, sitting on the hallway floor, and smelling of alcohol. The unlicensed personnel contacted the nurse. The resident was free from injury and vital signs were within range for the resident. The resident stood up and was able to walk normally with the use of her walker. Approximately half an hour later while an unlicensed personnel administered medications to the resident, the resident became unsteady and leaned on the unlicensed personnel who lowered the resident to the floor. The unlicensed personnel contacted the nurse. The resident was free from injury, vital signs were within range for the resident, and the resident's family were contacted. The resident was placed on hourly checks. Approximately one hour later, unlicensed personnel found the resident sitting on the floor next to her bed with a cut on her head. Vital signs revealed a lower blood pressure, and the resident was sent to the hospital where she received three staples to the cut on her head. No other injury was noted.

During interview, a leadership member stated the resident could become unsteady while drinking alcohol. When staff believed the resident was drinking, staff contacted the resident's family and increased resident safety checks. The leadership member stated the resident and the resident's family did not want the resident drinking alcohol and the facility assists with these wishes by monitoring the resident, not taking the resident to the liquor store during shopping outings, and locking up and dispensing the resident's alcohol mouthwash.

During interview, an unlicensed staff member stated alcohol was removed from the resident per the resident's and family's request, however, the resident hid alcohol and mouthwash from staff members at times and denied drinking. The unlicensed staff member stated the nurse was contacted during the time in question and the resident was checked hourly.

During interview, a family member stated he did not have any concerns regarding the facility's care of the resident during the time of the fall and the cause of the fall could have been related to low blood pressure issues. The family member stated the facility has been communicating with the resident, resident's family, and provider to best assist the resident.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

**“Not Substantiated” means:**

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

**Neglect: Minnesota Statutes, section 626.5572, subdivision 17**

“Neglect” means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means 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.

**Vulnerable Adult interviewed:** Yes.

**Family interviewed:** Yes.

**Alleged Perpetrator interviewed:** Not Applicable.

**Action taken by facility:**

Ongoing care plan creation with resident and family regarding alcohol use.

**Action taken by the Minnesota Department of Health:**

No further action taken at this time.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/19/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ABILIT HOLDINGS (PRAIRIE MEADOW) LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>800 5TH AVE NW KASSON, MN 55944</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL240536552C/#HL240539025M #HL240538953C/#HL240531401M</p> <p>On March 19, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 56 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for #HL240536552C/#HL240539025M, tag identification 2360.</p>	0 000		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.</p>	02360		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Minnesota Department of Health

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02360	<p>Continued From page 1</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p>	02360	No plan of correction is required for this tag.	