Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL240532886M
Compliance #: HL240534826C

Date Concluded: July 13, 2023

Name, Address, and County of Licensee Investigated:
Abilit Holdings Prairie Meadow
800 5th Avenue Northwest
Kasson MN, 55944
Dodge County

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

Evaluator's Name: Kris Detsch, 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 alleged perpetrator (AP) neglected a resident when they failed to direct staff to get the resident out of bed and give her food and fluids. As a result, the resident's health declined.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident received services from a hospice agency and the AP directed staff to follow the hospice plan of care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted hospice care providers. The investigation included review of resident records and employee files. Also, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia (memory loss), depression, failure to thrive, and delirium. The resident's service plan included assistance with housekeeping, medications, meals, dressing, grooming, bathing, mobility, and toileting. The resident's nursing assessment indicated the resident was on hospice care services and her health was declining. The nursing assessment indicated the resident had multiple falls and required increased assistance with mobility and transfers.

During a one-month period around the time of the alleged incident, the resident's progress notes indicated the resident had increased swallowing difficulties when she ate, and an overall decline in her health. Eventually, the resident required puree texture food. The progress notes indicated there were days the resident would not eat or drink. The resident began to vomit and required medication to control nausea and vomiting. In addition, staff observed the resident did not have any urine output for two-day period. The resident's progress notes indicated staff offered the resident food and fluid and got her up into the Broda chair. The resident's progress notes indicated hospice staff changed the resident's medications multiple times and were involved in care planning.

The resident's medical record indicated a nurse practitioner (NP) observed the resident about three weeks prior to the alleged incident. The NP's note indicated the resident had a decline in her physical and mental health and was sleeping about twenty-two hours a day. The NP's note indicated the resident was sleeping in her Broda chair during her exam and appeared to be comfortable.

The resident's treatment administration record (TAR) indicated staff repositioned the resident every two hours and provided incontinent cares. The TAR indicated staff encouraged the resident to take food and fluids. The TAR indicated staff offered the resident extra fluids at meals and snack times.

During an interview, an unlicensed personnel (ULP) said the resident lived in memory care because she had advanced memory loss. The ULP said the resident received services from a hospice agency and her health was declining. The ULP said the resident had multiple falls and increased difficulty walking. The ULP said the resident required a Broda chair (oversized, reclining wheelchair), assistance from two staff members, and a mechanical lift to get her into the Broda chair. The ULP said there were differences in the staff's opinions when to get the resident out of bed and into the Broda chair. The ULP said there was one incident where the resident was in bed for several days and she requested staff get the resident out of bed and into the Broda chair. Staff told her the AP told them they were not supposed to get the resident out of bed because she was minimally responsive. The ULP said she did not agree with the AP. The ULP said the resident appeared comfortable in bed at the time but felt staff should have gotten her up.

During an interview, the AP said the resident walked when she admitted into the facility, however her health status declined quickly. The AP said the resident required increased

supervision and had multiple falls. The AP said the resident required assistance with all her cares. The AP said the resident had “good days” and “bad days” and she slept often. The AP said the resident even slept when she was in the Broda chair. The AP said the resident’s eating and drinking would also vary. The AP said there were days the resident ate and drank very little, but then there were days she ate everything on her plate. The AP said the care plan directed ULP to offer the resident food and fluids, but they could not force her to eat. The AP said there were days when the resident was sleepy and would stay in bed, but she encouraged staff to get her up into her Broda chair. The AP said the care plan directed staff to reposition and provide skin cares to the resident when she was in bed. The AP said hospice caregivers were involved in care planning and they directed the resident’s end of life plan of care.

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:
(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.

Vulnerable Adult interviewed: No. Deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility worked in collaboration with hospice care providers.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24053	A. BUILDING: _____ B. WING _____	C 07/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

(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
0 000	Initial Comments On July 5, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL240534826C/#HL240532886M. No correction orders are issued.	0 000		