

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL31433001M
Compliance #: HL31433002C

Date Concluded: March 8, 2022

Name, Address, and County of Licensee

Investigated:

Prelude Homes & Services LLC
10020 Raleigh Road
Woodbury, MN 55129
Washington County

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

Evaluator's Name: Willette Shafer, RN
Special Investigator

Finding: Substantiated, individual 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 alleged perpetrator (AP) abused the resident when the AP hit the resident in the face with his hand.

Investigative Findings and Conclusion:

Abuse was substantiated. The AP was responsible for the maltreatment. The AP hit the resident in the face with his hand.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator toured the facility and observed staff and resident interactions. The investigator reviewed the resident's medical record, internal investigation, and agency policies. In addition, the investigator contacted law enforcement and reviewed the police report.

The resident lived on the memory care unit for one and a half years prior to the incident due to diagnoses that included dementia, osteoarthritis, and cervical spondylosis. The resident received services with bathing, dressing, grooming, toileting, medication administration, meal set-up, and housekeeping.

According to the police report, the AP attempted to redirect the resident from ripping up a placemat. The resident became agitated and hit the AP in the face. The AP hit the resident back in the face with an open hand causing the resident to fall to the ground. The AP was terminated and escorted off the property. No criminal charges were filed.

According to the facility's internal incident report, the resident hit the AP in the face and the AP slapped the resident back, hitting him in the face. Another resident's family member witnessed the incident. An unlicensed personnel (ULP)-E worked in the area but did not witness the incident. ULP-E observed the resident on the floor after the incident happened. The resident was assessed, and no injuries were noted.

During an interview, ULP-F stated she worked as the team lead during the incident. ULP-F stated the AP called her and reported the incident. ULP-F stated the AP reported the resident hit him in the face and then the AP stated he "blacked out". ULP-F stated the AP reported he remembered the resident on the ground and thought he hit the resident with a closed fist.

During an interview, ULP-E stated she was feeding another resident during the incident. ULP-E stated she observed the resident on the ground and the AP standing next to him. ULP-E stated she helped the resident up. ULP-E stated the resident pointed at the AP and said, "he hit me."

During an interview, the health and wellness coordinator (HWC) stated she conducted the internal investigation. HWC stated she interviewed the family member (FM) who witnessed the incident and the FM reported she witnessed the resident hit the AP and then the AP hit the resident in the face. HWC stated it was reported the resident fell to the ground after the AP hit him. HWC stated the resident was assessed after the incident and no injuries were reported. HWC stated the two days later the resident had a bruise on his face.

During an interview, licensed assisted living director (LALD) stated the AP told her he hit the resident in the face on instinct, after the resident hit him. LALD stated the police were contacted and the AP was terminated.

In conclusion, abuse was substantiated.

Abuse: Minnesota Statutes section 626.5572, subdivision 2

"Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

Vulnerable Adult interviewed: No, due to cognitive deficit.

Family/Responsible Party interviewed: No, due to lack of knowledge regarding incident.

Alleged Perpetrator interviewed: No, never returned requests for interview.

Action taken by facility:

The facility conducted an internal investigation. The AP was terminated.

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. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Washington County Attorney

Woodbury City Attorney

Woodbury Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31433	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/26/2022
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NAME OF PROVIDER OR SUPPLIER PRELUDE HOMES & SERVICES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 10045 ANTRIM COURT WOODBURY, MN 55129
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0 000	<p>Initial Comments</p> <p>Initial comments *****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING 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>#HL31433002C/#HL31433001M</p> <p>On January 26, 2022, 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 28 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction orders are issued for #HL31433002C/#HL31433001M, tag identification 0620, 2360, and 3000.</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 evaluators' findings is the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>	
0 620 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma	0 620		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 620	<p>Continued From page 1</p> <p>144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report suspected maltreatment within 24 hours to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1) with records reviewed.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1's medical record was reviewed. R1 was admitted to the facility on March 30, 2021. R1's diagnoses included Alzheimer's dementia, osteoarthritis, and cervical spondylosis. R1's service plan, dated January 26, 2022, indicated R1's behaviors included agitation and required staff to document behavioral interventions attempted.</p>	0 620		

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0 620	<p>Continued From page 2</p> <p>R1's Individual Abuse Prevention Plan (IAPP) dated November 12, 2021, indicated R1's behaviors included irritability, impulsivity, and indicated R1 was vulnerable to be abused by others. R1's IAPP included interventions for these behaviors and area of vulnerability.</p> <p>According to the police reported dated November 15, 2022, R1 hit unlicensed personnel (ULP)-A in the face and ULP-A slapped the resident back.</p> <p>R1's progress note dated November 15, 2021, indicated 911 was called after R1 hit ULP-A in the face and then ULP-A slapped R1 back.</p> <p>R1's progress note titled "Incident Follow Up," dated November 17, 2021, indicated R1 had a bruise on his face.</p> <p>On January 26, 2022, at approximately 12:15 p.m., licensed assisted living director (LALD)-D stated staff reported the incident to her the evening it occurred. LALD-D stated it was reported R1 hit ULP-A in the face, then ULP-A hit R1 back in the face. LALD-D stated the police were called and investigated the incident. LALD-D stated the incident was reported to MAARC on November 18, 2021.</p> <p>The licensee's policy Vulnerable Adult Maltreatment-Prevention & Reporting, dated August 1, 2021, indicated staff are to report maltreatment to MAARC, within 24 hours after the maltreatment was first suspected.</p> <p>TIME PERIOD TO CORRECT: Seven (7) days</p>	0 620		
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	<p>Continued From page 3</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> <p>This MN Requirement is not met as evidenced by: Based on interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was abused.</p> <p>Findings include:</p> <p>On March 8, 2022, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.</p>	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	
03000 SS=D	<p>626.557 Subd. 3 Timing of report</p> <p>(a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:</p> <p>(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the</p>	03000		

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03000	<p>Continued From page 4</p> <p>previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report suspected maltreatment within 24 hours to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one</p>	03000		
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03000	<p>Continued From page 5</p> <p>resident (R1) with records reviewed.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1's medical record was reviewed. R1 was admitted to the facility on March 30, 2021. R1's diagnoses included Alzheimer's dementia, osteoarthritis, and cervical spondylosis. R1's service plan, dated January 26, 2022, indicated R1's behaviors included agitation and required staff to document behavioral interventions attempted.</p> <p>R1's Individual Abuse Prevention Plan (IAPP) dated November 12, 2021, indicated R1's behaviors included irritability, impulsivity, and indicated R1 was vulnerable to be abused by others. R1's IAPP included interventions for these behaviors and area of vulnerability.</p> <p>According to the police reported dated November 15, 2022, R1 hit unlicensed personnel (ULP)-A in the face and ULP-A slapped the resident back.</p> <p>R1's progress note dated November 15, 2021, indicated 911 was called after R1 hit ULP-A in the face and then ULP-A slapped R1 back.</p> <p>R1's progress note titled "Incident Follow Up," dated November 17, 2021, indicated R1 had a</p>	03000		

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