Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL322763020M
Compliance #: HL322762965C

Date Concluded: September 18, 2024

Name, Address, and County of Licensee Investigated:
Prelude Homes White Bear Lake
4650 White Bear Parkway 102
White Bear Lake, MN 55110
Ramsey County

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

Evaluator's Name: Lori Pokela
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 resident when staff failed to implement fall interventions and failed to assess the resident after a change in condition. The resident was transferred to the hospital, diagnosed with multiple pelvic fractures, and died the next day.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident's plan of care was followed at the time of the incident(s) and staff notified the nurse and updated the resident's physician when a change in condition was observed. The resident was sent to the hospital for further evaluation, admitted to hospice and passed away the following day.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record(s), death record, hospital records, facility internal investigation documentation, incident reports, personnel files, staff schedules, and related facility policies and procedures. Also, the

investigator observed staff interactions, medication and treatment administration and resident cares at the time of the onsite visit.

The resident resided in an assisted living assisted living memory care unit with a diagnosis of Alzheimer's disease. The resident's service plan included assistance with dressing, grooming, medication management, and safety checks seven times per day. The resident's assessment indicated the resident was not able to utilize the facility's emergency call system due to impaired cognition, confusion, and memory loss, and noted that the resident did not have a history of falls and was independent with toileting, transfers, and ambulation.

One day, staff noted the resident had an increase in confusion and required staff assistance with dressing. The resident also complained of low back and hip pain which was not fully relieved with as-needed (PRN) pain medication. Th resident also had a poor appetite and was unsteady with ambulation. Staff reported these changes to the facility nurse, who instructed staff to encourage the resident to stay in the common community areas and provide additional transfer and ambulation assistance to ensure the resident's safety. The nurse updated the resident's physician and family of the resident's change in condition. The physician ordered an antibiotic as a preventative measure against a possible urinary tract infection (UTI) and informed the nurse they would visit the resident the next day at the facility.

The next day, the resident continued with complaints of pain, a poor appetite and reported that she "didn't feel like herself". The physician assessed the resident and ordered laboratory tests and increased the resident's pain medication.

The following morning, staff found the resident lethargic (fatigued), sweating, and not responding normally. The resident told staff she needed to see the doctor. Facility staff observed blood on the resident's bedsheets and undergarments. Staff immediately contacted the nurse, who instructed to call staff to call the resident's family and emergency medical services (EMS). Staff called the resident's family and 911 and the resident was transported to the hospital.

The resident's hospital records indicated the resident had an infection, multiple pelvic fractures, and noted that a fracture fragment had pierced through the wall of the resident's bladder. The resident was not a candidate for surgical repair of the fractures and was admitted to hospice care.

The resident returned to the facility and passed away the next day.

During an interview, nurse management staff stated the resident was typically independent with transfers, toileting, and mobility. The resident walked independently around the unit without assistance and did not like to request assistance from staff. Nurse management staff stated that a couple of days prior to hospital admission, the resident was treated for a UTI but

did not fully respond to treatment measures. Nurse management staff stated that staff assisted the resident with mobility as needed, and updated the family and physician regularly.

During an interview, facility administrative staff recalled that the day before the resident was sent to the hospital, observed the resident participating in a group activity program. The administrative staff stated they observed staff assisting the resident and noticed that the resident walked slower than usual and had an unsteady gait.

During an interview, unlicensed staff, who worked the night before the resident was sent to the hospital, stated safety checks were completed per the resident's plan of care and last checked on resident at approximately 7:00 am. The staff stated that the resident was in bed, was awake and said "hello" in response to their morning greeting.

During an interview, dayshift unlicensed staff stated that two days before the resident was hospitalized, the resident was acting unusual and unable to dress herself. The dayshift staff observed the resident's gait was very unsteady and called the floor nurse immediately to report the noted change in condition. The nurse then instructed all staff to take turns and encourage the resident to stay in the common community areas to provide additional monitoring and supervision of the resident. Two days later, when the resident was found lethargic with blood on the bedsheets, the nurse instructed her to call and update the resident's family and obtain consent to send the resident to the hospital, then call 911. The unlicensed staff called and left a voice message with the resident's family then called nursing management to request to call 911 without family consent. Nurse management directed her to call 911 and obtain the resident's vital signs.

During an interview, the resident's family stated they were updated by the facility regarding the change in the resident's condition and being sent to the hospital. The family member recalled the facility reported the resident had unusual behaviors with dressing and a poor appetite. The family did not recall any information about changes in the resident's ambulation but stated the resident wished to be independent, had a high pain tolerance, and preferred to stay in her room verses large group settings.

In conclusion, the Minnesota Department of Health determined abuse 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: No. Deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes, Not Applicable.

Action taken by facility:
Nursing staff observed and assessed the resident's change in condition and updated the family, the physician, and sent the resident to the hospital for further evaluation.

Action taken by the Minnesota Department of Health:

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
	32276	A. BUILDING: _____ B. WING _____	C 06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRELUDE HOMES & SERVICES LLC	4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110

(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 June 24, 2024, the Minnesota Department of Health conducted a complaint investigation of HL322762965C/HL322763020M at the above provider. No correction orders are issued.	0 000		