Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326089146M
Compliance #: HL326086837C

Date Concluded: May 14, 2024

Name, Address, and County of Licensee Investigated:
Pioneer Estates
8761 Preserve Boulevard
Eden Prairie, MN, 55344
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, 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 staff failed to provide daily dressing changes, according to the provider order, for the resident who had a known pressure ulcer. As a result, the resident's pressure ulcer worsened requiring a procedure.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Staff provided the resident daily wound care as ordered. The facility arranged for evaluations of the resident pressure ulcers at a wound clinic and updated the resident's providers on wound status. Despite staff education, the resident chose to remain in his wheelchair for an extended periods of time. In addition, the facility arranged for a wheelchair cushion, new bed and a power wheelchair that allowed the resident the ability to reposition independently.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's case worker. The

investigation included review of the resident's record, hospital records, and facility policy and procedures. Also, the investigator toured the facility and observed the resident.

The resident resided in an assisted living facility. The resident's diagnoses quadriplegia (paralysis of all four limbs) and diabetes. The resident's service plan included assistance with daily wound care and range of motion exercises. The resident's assessment indicated the resident was alert and oriented.

The resident record indicated one day during a visit to a wound clinic, the clinic staff arranged for the resident to be evaluated at a hospital for possible signs of infection and surgical debridement of a pressure ulcer of the right ischial tuberosity (IT) or sitting bone.

Emergency room records indicated the resident was evaluated at the wound care clinic one to two times a month for an unstageable (full thickness skin and tissue loss where the extent of damage cannot be clearly seen due to presence of slough or dead skin tissue) coccyx (tailbone) and right IT pressure injuries. At the hospital, the resident underwent surgical debridement of a non-healing right IT ulcer. The resident was given antibiotics for the wound infection and hospitalized for seven days. The resident transferred to a higher level of care due to the facility's inability to accommodate discharge orders of dressing changes twice a day.

The resident required a 17 day stay at a higher level of care and returned to the facility with orders for once daily wound care.

During an interview, a nurse stated she was at the facility daily and came in on the weekends to perform the resident's wound care. The nurse stated when she was not available, trained unlicensed staff performed the task. The nurse stated the resident's wound care was provided daily according to orders. The nurse stated the resident's IT wound got larger quickly and frequently the resident chose to remain in the wheelchair instead of relieve pressure to his buttocks. Facility nursing staff and outside providers educated the resident on the benefit of getting out of the chair to promote wound healing. The nurse stated she contacted the resident's providers with changes in wound status and the resident was evaluated at the wound clinic one to two times a month. The resident went to the hospital for wound debridement and infection.

During an interview, a family member stated the resident had since received a new power wheelchair that allowed the resident to lean back and forth to reposition and offload pressure.

During an interview, the resident stated everything at the facility was fine.

Additional concerns identified in the complaint included failure of staff to complete the resident's range of motion exercises. The resident had scheduled physical and occupational therapy appointments. Another concern included the resident receiving microwaved meals.

Leadership stated the resident received three meals a day with nutritional value. The resident had no signs of malnutrition including weight loss.

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/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility sent the resident to scheduled wound clinic visits. The facility updated providers on wound status, educated the resident on offloading pressure, arrange for the resident to receive new bed, wheelchair cushion and power wheelchair.

Action taken by the Minnesota Department of Health:
No further action 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
	32608	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER ESTATES	8761 PRESERVE BOULEVARD EDEN PRAIRIE, MN 55344

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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: #HL326086837C/#HL326089146M #HL326084915C On April 8, 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 21 residents receiving services under the provider's Assisted Living license. No correction orders are issued for #HL326086837C/#HL326089146M. . The following correction order is issued for #HL326084915C, tag identification 0460.	0 000		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours	0 460		

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0 460	Continued From page 1 per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee did not have a system in place for residents at the facility to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all residents residing at the facility. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 460	Minnesota Department of Health is documenting the State 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. PLEASE DISREGARD THE HEADING OF	

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0 460	Continued From page 2 The licensee held an assisted living license and was licensed for a bed capacity of 30 residents. The resident roster indicated the licensee's campus consisted of three houses. The houses were titled House 1, House 2, House 3, and indicated the following: House #1 had a census of 5 residents. House #2 had a census of 7 residents. House #3 had a census of 9 residents. During an observation on April 8, 2024, at 10:58 a.m., the campus consisted of three separate houses with separate entrances accessible by an outside centralized parking lot. Operations Manager (OM)-I stated each of three houses layout were identical consisting of three levels. Lower levels were unused by residents, main levels consisted of communal dining, living, and kitchen space, and a hallway of resident rooms. Upper levels consisted of more resident rooms. During an observation on April 8, 2024, at 11:05 a.m., House #1's upper level was accessible by a door located on the main level in the hallway with resident rooms. A chair lift was observed on the staircase. The upper level consisted of a hallway with resident rooms. During an interview on April 8, 2024, at 11:10 a.m., unlicensed personnel (ULP)-J stated House #1 had residents who used a "baby monitor" to summon for assistance from staff to their rooms. The baby monitors were used for residents who were physically unable to use their arms to press a call pendent. Staff could hear when a resident spoke into a baby monitor from the main monitor located in the communal space. ULP-J stated residents on the upper level were independent,	0 460	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 144G.31 SUBDIVISION 1-3.	

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0 460	Continued From page 3 did not have a way to summon for staff assistance, however had the ability to walk down the stairs if they needed staff assistance. During an observation on April 8, 2024, at 11:14 a.m., ULP-L stated House #2 had a call system. All residents had call pendants and staff were aware a resident called for assistance by visually seeing and hearing the call pendent number announced on a centralized monitor. When the monitor was cleared for one resident, all the calls cleared out at the same time and prior calls were canceled out. During an interview on April 8, 2024, at 11:25 a.m., OM-I and ULP-D, stated the licensee had two residents in House #1 that used baby monitors in their rooms to request staff assistance. The two residents were unable to physically use their arms and were unable to press a call pendent. The licensee was currently working on purchasing a specialized call system for these residents. All the other residents on campus had a call pendent. They stated House #1, House #2, and House #3 all had monitor boxes centrally located in each individual house. The call system was individualized for each house not the entire campus. When a resident used a call pendent in one of the houses the number flashed, made an audible sound on the monitor to alert staff. If more than one resident used a call pendant at the same time the numbers continued to flash and made the audible sound. The call system was not cleared out on an individual resident pendent; all resident calls were cleared out at the same time, not individually. Staff were directed if more than one resident summoned for assistance at the same time, staff wrote down the room numbers of the other residents before clearing out the system.	0 460		

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0 460	Continued From page 4 During an interview on April 8, 2024, at 2:00 p.m., ULP-J stated staffing consisted of the following daily: House #1 AM shift: one unlicensed personal PM shift: one unlicensed personnel Overnight shift: one unlicensed personnel ULP-J stated staff left House #1 unattended to assist in a different house when needed to assist staff with mechanical lift transfers or to get food. During an interview on April 8, 2024, at 2:10 p.m., ULP-K stated staff scheduled consisted of the following daily: House #1 AM shift: one unlicensed personal PM shift: one unlicensed personnel Overnight shift: one unlicensed personnel House #2 AM shift: two unlicensed personnel PM shift: one unlicensed personnel Overnight shift: one unlicensed personnel House #3 AM- two unlicensed personnel PM- two unlicensed personnel Overnight shift- two unlicensed personnel ULP-K stated house #2's second staff on day shift was a float staff and floated between all the houses. House #2 had residents who required mechanical lift transfers with two staff. Staff from House #1 left the house to assist staff in House #2 with the mechanical lift transfers. ULP-K stated staff from House #1 and House #2 worked together for mechanical lift transfers. ULP-K stated when staff left the house unattended, they	0 460		

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0 460	Continued From page 5 would not know a resident requested assistance because the call system was individualized for each house. The staff who left would not be able to hear a resident who requested assistance from a different house. During an interview on April 8, 2024, at 2:15 p.m., ULP-L stated the call system was individualized to each house. Staff who left a house unattended would not be able to hear or know a resident from the unattended house requested assistance. During an interview on April 8, 2024, at 2:20 p.m., licensed practical nurse (LPN)-A stated staff unlicensed personnel left a house unattended when another staff at a different house needed assistance with mechanical lift transfers or to get food. LPN-A stated for the residents who were physically unable to use their hands and arms the call system consisted of baby monitors; all other residents have call pendants. LPN-A stated when staff left a house unattended, they would not be able to hear or know a resident from the unattended house requested assistance. The Uniform Disclosure of Assisted Living Services and Amenities dated July 10, 2023, indicated the licensee had an emergency and non-emergency call system. The comments indicated "ValUCare Call Light System". The not dated or signed Direct-Care Staffing Plan, indicated staff would meet the resident's scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises in a timely manner on a 24-hour per day basis. There would be 24-hour, awake staff available to respond to resident requests for assistance with health and safety needs. When resident's require a two-person	0 460		

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0 460	Continued From page 6 assist there would be a minimum of two staff available at all times. Between the hours of 10:00 p.m. and 6:00 a.m. there would be direct-care staff able to respond to a resident's request for assistance with health and safety needs within a reasonable amount of time. These staff would be located within the campus in order to respond. A policy regarding a means for residents to request assistance and/or call system was requested but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 460		