DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL33424001M
Compliance #: HL33424002C

Date Concluded: September 28, 2022
Revised: July 11, 2023

Name, Address, and County of Licensee Investigated:
Peaceful Lodge
6630 Hudson Blvd
Oakdale, MN 55128
Washington County

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

Evaluator's Name: Christine Bluhm, RN
Lena Gangestad, RN
Special Investigators
Revised by Matt Heffron, JD, Manager

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.

Initial Investigation Allegation:
The facility abused a resident when they restrained the resident to the wheelchair with a gait belt during a transfer by vehicle to the resident's dialysis appointment. The resident was lethargic, confused, vomiting and unable to follow commands.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined that abuse was inconclusive. However, neglect was substantiated when the alleged perpetrator (AP) failed to provide appropriate interventions according to acceptable health care standards, medical or nursing standards for the resident before she was sent to her dialysis appointment. **The AP was responsible for the maltreatment.** The AP, who was also the director of nursing, sent the resident to the dialysis appointment when she was disoriented, vomiting and not able to stay safely seated in the wheelchair. The AP placed a transfer type gait belt (a belt not part of the wheelchair) around

the resident while she was seated in the wheelchair to keep the resident from slumping down and sliding out of the chair. When the resident reached the dialysis center, she was sent to the hospital for further evaluation.

The investigator conducted interviews with facility staff members, the AP, and unlicensed staff. The investigator also contacted the dialysis center nurse. The investigation included a review of facility incident reports, the resident's record and the records of other residents who used a wheelchair for mobility. Also, while on site at the facility, the investigator observed another resident who got into the transport vehicle to a dialysis appointment and observed no concerns.

The resident resided in an assisted living facility. The resident's diagnoses included end stage renal disease with dialysis three days a week, right sided hemiplegia, and congestive heart failure. The resident's service plan included services for all personal cares, medications, meals, and housekeeping. The resident's assessment indicated she required staff assistance with all activities of daily living which included mobility from the bed to the chair with the assistance of one staff and staff escort and transportation assistance to and from medical appointments. The resident's restraint assessment that was done the morning the resident was sent out for the dialysis appointment, indicated the resident had impaired decision making, was unstable, with total loss of ability to balance self and had poor body alignment. It also indicated the resident had emesis three times, appeared lethargic, and repeatedly slid out of her wheelchair. The same document indicated a "lap belt/restraint" was applied while waiting for the transportation to her dialysis treatment.

Review of the resident's nursing progress note indicated resident had fallen four times in two days. Vitals signs and assessment were done, and the facility registered nurse was notified.

During an interview, the AP stated the resident was incoherent, more lethargic than usual and vomited a few times while she and her assistant were getting the resident ready for the dialysis appointment. The resident slumped down in the wheelchair and was unable to stay seated in the wheelchair. The AP stated she put the gait belt around the resident and the chair to keep her safe and so she would not slide out of the chair during transport to the dialysis center. The AP stated that she did not have an available staff person to accompany the resident during the transport.

During an interview, a nurse at the dialysis center stated the resident arrived at the clinic, strapped into the wheelchair with a gait belt under her arms. The nurse stated the resident the resident was not oriented enough to remove the belt on her own, and not able to answer any questions or stand on her own. The resident had vomited on the front of her shirt in the bag which was taped to the front of her shirt. The dialysis center staff sent the resident to the hospital for further evaluation.

In conclusion, the Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(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;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No, the resident was no longer at the facility.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
None

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.

cc:
Office of Ombudsman for Long Term Care
Office of Ombudsman for Mental Health and Developmental Disabilities
Washington County Attorney
Oakdale City Attorney
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33424	A. BUILDING: ______ B. WING ______	C 07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL LODGE	**6630 HUDSON BOULEVARD** **OAKDALE, MN 55128**

(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****** REVISED ASSISTED LIVING PROVIDER LICENSING 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: #HL33424002C/#HL33424001M On July 14, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 44 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL33424002C/#HL33424001M, tag identification 2310 and 2360. On August 15, 2023, the 2360 tag was revised to reflect responsibility for the maltreatment in accordance with the revised maltreatment report.	0 000	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. 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. 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.	
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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

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02310	Continued From page 1 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update the physician or the dialysis center on the resident's physical condition before sending to a dialysis appointment for one of four (R1) residents records reviewed. Additionally, the licensee failed to provide appropriate intervention during the transport according to acceptable health care standards, medical or nursing standards by applying a gait belt around R1 and R1's wheelchair. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). The findings include: R1's diagnoses included diabetes mellitus type 2, dialysis end-stage renal disease and right-sided hemiplegia. R1's service plan dated March 4, 2022, indicated R1 required services with all personal cares, medications, meals, and housekeeping. R1's assessment dated March 4, 2022, indicated	02310		

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02310	Continued From page 2 she required staff assistance with all activities of daily living which included mobility from the bed to the chair with the assistance of one staff. R1's restraint assessment dated March 8, 2022, indicated R1 had impaired decision making, was unstable, with total loss of ability to balance self and had poor body alignment. The same document indicated the resident had emesis three times, appeared lethargic, and repeatedly slid out of her wheelchair. The same document indicated a "lap belt/restraint" was applied while waiting for the transportation to her dialysis treatment. The same document did not include information whether the restraint should remain in place during transport. The portion of the document for team review included a nurse signature, but the other signatures include occupational/physical therapy, social services, and the physician remained blank. R1' s planned services as of date July 14, 2022, indicated staff accompany resident to medical appointments due to cognition, or physical limitations or medical procedure requirements per physician or clinic. The services also included dialysis appointment reminder with instructions to wake up and assist resident with getting dressed and ready to go to dialysis. R1's medical record indicated R1's dialysis schedule was every Tuesday, Thursday, and Saturday at 10:40 a.m. with pick-up scheduled at 9:30 a.m. When interviewed on July 14, 2022, at 11:30 a.m., registered nurse (RN)-A stated R1's wheelchair did not have a safety belt, so RN-A placed a gait belt around R1 and her wheelchair to prevent R1 from slumping down for her dialysis	02310		

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02310	Continued From page 3 appointment. RN-A stated the R1 was lethargic with intermittent vomiting at the time the licensee prepared her for her appointment. Additionally, RN-A stated R1 slipped out the chair three times that morning prior leaving for her dialysis appointment. RN-A stated she sent R1 to her appointment without updating the dialysis center about R1's condition. RN-A confirmed R1 was more lethargic than usual so she would not be able to take the gait belt off herself. When interviewed on July 25, 2022, at 4:16 p.m., RN-C, who is employed by the dialysis center, stated R1 arrived for her dialysis appointment in March she was strapped in her wheelchair with a gait belt under her arm. RN-C stated R1 arrived disoriented and unable to able to answer questions, unable to stand on her own, and had vomited on herself and into a bag taped to the front of her shirt. RN-C immediately sent R1 to the hospital. RN-C confirmed on August 10, 2022, via email R1 would not have been able to unbuckle the gait belt herself. Licensee policy titled 6.01 Assessments, Reviews & Monitoring dated July 1, 2021, indicated ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident. TIME PERIOD FOR CORRECTION: Seven (7) Days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment	02360		

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02360	Continued From page 4 covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On September 28, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and an individual alleged perpetrator were 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.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

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