Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL346016603M
Compliance #: HL346019902C

Date Concluded: January 15, 2025

Name, Address, and County of Licensee Investigated:
Prelude Homes and Services
10018 Raleigh Road
Woodbury, MN 55129
Washington County

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

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Substantiated, individual responsibility

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) abused the resident when the AP pushed the resident down to the floor two separate times. The resident sustained a skin tear and bruising to his left elbow.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP attempted to redirect the resident when he saw the resident trying to enter a peer's room. The resident became agitated, and the AP pushed the resident to the floor. The resident struggled to get up and again approached the AP. The AP pushed the resident down to the floor again. The resident hit his head on a wall and sustained a skin tear to his left elbow.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident records, the facility internal investigation, facility

incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident interactions with staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's services included assistance with personal hygiene, dressing, securing and managing healthcare, meals, housekeeping, laundry, and medication management. The resident's assessment indicated he was vulnerable to falls and injuries due to confusion. The resident required regular behavior monitoring due to disorientation, hallucinations, and wandering.

An incident report indicated the resident was "aggressive" with the AP resulting in an altercation, and the resident fell. The resident got himself up off the floor and tried to swing at the AP, causing the resident to fall again. After the second fall, staff helped the resident off the floor and notified a nurse. The resident sustained a skin tear on his left elbow.

An employee corrective action report indicated a recorded video of the incident showed the resident trying to enter a locked room. The AP stepped between the resident and the door. The resident became agitated, and the AP and resident began to struggle. The AP pushed the resident and the resident fell to the floor. The resident got himself up off the floor using a handrail on the wall and approached the AP throwing a punch. The AP took several steps toward the resident and the AP pushed the resident again and the resident fell backwards to the floor. The AP said he was trying to "defend himself."

The progress notes indicated staff reviewed camera footage and saw the resident fall twice during the incident with the AP. The resident was trying to get into a locked room and the AP moved in front of the door and told the resident he could not go into that room. The resident started to push past the AP when the AP leaned into resident, causing the resident to fall backwards onto the floor. The resident got himself up without help from the AP. The resident swung towards the AP and the AP pushed the resident, causing the resident to fall again.

Review of the facility video of the incident the resident was observed standing alone in a hallway, jiggling the door handle to a peer's room. The AP came down the hall and approached the resident. The resident continued to stand at the door and the AP stepped between the resident and the door. The resident struggled to reach the door around the AP. The AP pushed the resident back using his right arm and the fell backward on to the floor and hit his head on the wall. The AP stood over the resident without providing any assistance as the resident attempted to get up from the floor. The resident crawled to the opposite side of the hallway and grabbed a handrail with both hands to get himself up off the floor. The resident stood up in front of the AP, who had his back to the video. There appeared to be a continued conversation between the AP and the resident. The AP walked toward the resident and again, with his right arm, pushed the resident away from him, causing the resident to fall backward to the floor a second time. A second staff member ran to the scene as the resident laid on the floor. The video ended.

When interviewed, a facility leader stated she reviewed the video and saw the AP contributed to the resident falling to the floor.

When interviewed, a supervisor stated he reviewed the video and observed the AP push the resident to the floor twice. The supervisor stated all staff were trained in de-escalation techniques, as well as how to interact with each individual resident.

When interviewed, the AP stated he was trying to prevent a confrontation between the resident and a peer when the resident tried to enter the peer's room. A struggle ensued and the resident lost his balance, falling to the floor. The AP stated the resident hit him twice, and denied he caused the resident to fall.

The AP's training files indicated he received training in the aging process, the Assisted Living Bill of Rights, communication, person-centered care, dementia care, and vulnerable adult. The AP's performance evaluation form from the beginning of the year indicated the AP needed to "learn how to redirect."

In conclusion, the Minnesota Department of Health determined abuse was substantiated.

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.

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; or

(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 unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(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, unable.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility provided refresher training to staff in de-escalation techniques. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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

You may also call 651-201-4200 to receive a copy via mail or email.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34601	A. BUILDING: _____ B. WING _____	C 12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRELUDE HOMES AND SERVICES	10018 RALEIGH ROAD WOODBURY, MN 55129

(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: #HL364019902C/#HL346016603M On December 13, 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 51 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL364019902C/#HL346016603M, tag identification 2360.	0 000	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 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		