MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Prairiewood Home	HG414002	May 26, 2016
Facility Address:	**Time of Visit:**	**Date Concluded:**
2736 LeHomme Dieu Heights NE	11:00 a.m.-3:30 p.m.	January 26, 2017
Facility City:	**Investigator's Name and Title:**	
Alexandria	Jill Hagen, RN	

State:	ZIP:	County:
Minnesota	56308	Douglas

☒ **ICF/IID**

Allegation(s):

It is alleged that a client was abused when the alleged perpetrator (AP) yelled at the client and pried the client's legs apart to do cares. The AP told the client to go to the client's room then the AP locked the door by jamming a butter knife in the molding to prevent the client from getting out of the room.

- ☒ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
- ☒ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, abuse occurred when the alleged perpetrator (AP) yelled at the client, struggled with the client, and secluded the client.

The client's diagnosis includes severe developmental disability. The client independently completes the majority of his/her activities of daily living with staff cues. The client required staff assistance with medication administration and the application of a treatment cream to the client's groin. The care plan indicated staff were to provide the client one short and specific prompt assist the client to his/her room, use distractions such as music, and provide positive reinforcement with interactions. For treatment refusals, the care plan directed staff to approach the client again at a later time. When an interview was attempted, the client could not verbalize specific information about the incidents.

During an evening shift, the facility had three staff scheduled to assist the clients. Staff #1 and Staff #2 observed the client refuse to allow the AP to apply a treatment cream to the client's groin. The client put his/her legs together firmly and verbally refused the treatment. The AP proceeded to try to pry the client's legs apart with force to apply the cream. The client responded by saying no. Both staff said the AP continued to attempt to pry the client's legs apart for about two minutes despite the client's refusal. There was no documentation of an injury to the client from the treatment.

According to Staff #1, around 7:30 p.m., the AP told the client to go to his/her room. Once the client

entered the room, the AP shut the door and placed a knife between the door molding and the door, preventing the client from leaving the room. The client banged on the door for about ten minutes. Staff #1 said after thirty minutes, the AP removed the knife from the door, but s/he did not open the door to check on the client. Staff #1 reported that the AP "yelled" at the client, when s/he repeated the same phrases over and over that evening. Staff #1 said s/he did not stop the AP or immediately report the AP's actions, because the AP is his/her friend.

According to a Staff #2, s/he came into the hallway, after being in another client's room, and saw the knife in the client's door frame. S/he knew it prevented the client from leaving the room. According to Staff #2, s/he did not hear the client banging on the door, but saw the knife in the door frame for about ten minutes.

When interviewed, the AP denied the allegations. S/he said the client grabbed the AP's hand tightly and refused to let go during the groin treatment. The AP was only insisting the client let go of his/her hand. The AP admitted putting a knife between the door molding and the door, which prevented the client from leaving the room. The AP said the knife was in place for only a few minutes but admitted it was the wrong thing to do.

An interview with the program director established the AP was suspended and would no longer be working at the facility after the investigation.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☒ Abuse ☐ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☒ Facility is responsible for the

☒ Abuse ☐ Neglect ☐ Financial Exploitation. This determination was based on the following:

The staff received training during orientation and annually regarding the facility's vulnerable adult policy and procedures that included the definition of abuse including unreasonable confinement and seclusion. In addition, staff education included the behavior management care plan for the client. Review of the personnel files for the three staff established they had all received the required training and were knowledgeable of the client's behavior care plan. Despite the training, one employee failed to intervene and prevent the AP actions toward the client and failed to report the AP's actions to the administration. Despite the training the AP received, the AP secluded the client, physically struggled to pry the client's legs apart and yelled at the client.

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.

Compliance:

Federal Regulations for ICF/IID (42 CFR, Part 483, subpart I) - Compliance Not Met
The requirements under Federal Regulations for ICF/IID (42 CFR, Part 483, subpart I) were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Supervised Living Facility (MN Rules Chapter 4665) - Compliance Not Met
The requirements under State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Prior to the on-site investigation, the facility educated all staff regarding their vulnerable adult reported policy and immediately reporting allegations of abuse of neglect to the administration.

Definitions:

Minnesota Statutes, section 626.5572, subdivision 2 - Abuse

"Abuse" means:
(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.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- ☒ Medical Records
- ☒ Care Guide
- ☒ Medication Administration Records
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Physician Orders
- ☒ Treatment Sheets
- ☒ Physician Progress Notes
- ☒ Care Plan Records
- ☒ Facility Incident Reports
- ☒ ADL (Activities of Daily Living) Flow Sheets
- ☒ Service Plan

Other pertinent medical records:

Additional facility records:

☒ Staff Time Sheets, Schedules, etc.
☒ Facility Internal Investigation Reports
☒ Personnel Records/Background Check, etc.
☒ Facility In-service Records
☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Two

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ○ Yes ○ No ◉ N/A

Specify: _____

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

◉ Yes ○ No ○ N/A Specify: Attempt, made client made simple yes/no responses

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Two

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Four

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ◯ Yes, date subpoena was issued _____ ◯ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Nursing Services
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Facility Tour

Was any involved equipment inspected: ◯ Yes ◯ No ◉ N/A
Was equipment being operated in safe manner: ◯ Yes ◯ No ◉ N/A
Were photographs taken: ◯ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

The Office of Ombudsman for Mental Health and Developmental Disabilities

Alexandria Police Department

Douglas County Attorney

Alexandria City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G414	A. BUILDING _____ B. WING _____	C 09/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308

(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) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint investigation was conducted to investigate case #HG414002. As a result, the following deficiency is issued.	W 000		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure an alleged incident of staff to client mistreatment was reported immediately to the administrator and state agency for 1 of 3 (C1) clients reviewed. Findings include: Observations made on 5/26/2016, at 1:46 p.m. revealed all of the client's bedrooms were located in one common hallway. C1's bedroom was located near the main living area of the house. C1's bedroom door opened out into the hallway. On 4/20/2016, the state agency received a report of alleged staff physical and verbal abuse of C1 that occurred on 3/31/2016. Review of C1's medical record indicated he was admitted to the facility on 2/23/2005, with diagnoses that included severe intellectual disability, microcephaly, idiopathic growth hormone deficiency or short stature, and disruptive behaviors. Review of C1's Comprehensive Functional Assessment dated	W 153		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G414	A. BUILDING _____ B. WING _____	C 09/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308

(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) COMPLETION DATE
W 153	Continued From page 1 5/13/2016, revealed C1 was independent in all areas of transfers and mobility. C1 required minimal assistance from staff for all activities of daily living (ADL)'s and was able to communicate his needs to staff. C1 required staff assistance with medication administration and skin treatments. Review of C1's Self-Management Assessment dated 5/13/2016, revealed C1 had a formal behavioral plan developed by a community resource. Review of C1's Active Treatment Program Plan revised on 8/15, and 5/16, revealed C1's target behaviors included physical aggression, inappropriate or unwanted behaviors such as repeating phrases, and verbal aggression. The program plan directed staff during episodes of target behaviors, to provide C1 with one short and specific verbal prompt informing him the behavior was inappropriate. If the behaviors continued, staff prompted C1 to leave the immediate area. No further attention was to be given to C1 until he no longer engaged in the target behavior. With aggression, staff reminded C1 to calm in order to be safe. When C1 engaged in socially appropriate behavior, staff were to praise C1 with specific feedback. In addition, frequently throughout the day, staff were to praise C1 for positive behaviors. Review of the facility's Complaint Report Form dated 4/16/2016, revealed on that date, Consumer Counselor (CC)-A placed a written complaint in the administrative office. The summary indicated on 3/31/3016, during the evening shift, CC-A observed CC-B yelling at C1 nose to nose. In an unspecified amount of time,	W 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G414	A. BUILDING _____ B. WING _____	C 09/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308

(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) COMPLETION DATE
W 153	Continued From page 2 CC-B told C1 to go to his room and followed behind him. Once C1 entered his room, CC-B shut the door leading to the hallway and placed a knife between the door frame and the door preventing C1 from exiting his room. In addition, earlier in the afternoon, CC-B forcefully pulled C1's legs apart to apply a treatment cream to C1's groin despite C1's verbal refusals. There was no documented injury to C1 following the groin treatment provided by CC-B. Management did not become aware of the written complaint until 4/18/2016, when CC-A told them the written report was hidden on a bookshelf in the office. An interview with the program director (PD) on 5/26/2016, at 1:15 p.m. established on 4/18/2016, no specific time, CC-A informed her that a written complaint alleging staff to client mistreatment had been hidden on a bookshelf in the PD's office. Three staff CC-A, CC-B, and CC-C were working the evening of 3/31/2016. CC-C was a new employee on orientation. Both CC-A and CC-C said CC-B locked C1 in his room by placing a knife between the doorframe and door of C1's room. C1 was unable to exit his room with the knife in place. CC-A said the knife remained in place for about 30 minutes. Also, CC-A reported CC-B forcefully applied a treatment cream to C1's groin despite his refusals. C1 should have approached the client to do the treatment later in the shift. Staff have been educated to keep a distance between C1 and themselves for safety and to attempt to deescalate C1's behaviors. CC-B should not have been yelling at C1 or close to his face. Attempts to deescalate C1's behaviors should have included contacting the community resource staff to provide staff support or diversional activities such as listening to music which C1's enjoys. CC-B was immediately	W 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G414	A. BUILDING _____ B. WING _____	C 09/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308

(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) COMPLETION DATE
W 153	Continued From page 3 suspended pending the results of the facility investigation. PD reported the incident the following day to the administrator because she thought the report was required in 24 hours and not immediately as directed by the facility policy. PD said CC-B would no longer be employed at the facility. Interview with CC-C on 5/26/2016, at 2:32 p.m. established CC-C was working the evening shift on 3/31/2016, with CC-A and CC-B. Between 3:00 and 4:00 p.m. following C1's bath, CC-C witnessed CC-B apply an ointment to C1's groin. CC-C was on orientation and observing the treatment to C1. CC-B was with C1 who was refusing to open his legs and verbally refusing the treatment. CC-B attempted to "pry" open C1's legs for about two minutes to apply the cream. C1 responded by yelling "no" at CC-B and becoming more aggressive. Later that evening CC-C was in another client's room assisting with cares and upon entering the hallway CC-A showed her the knife between the doorframe and door of C1's room. CC-A told CC-C that CC-B place the knife in C1 doorway. CC-C observed the knife in the doorframe for about ten minutes. CC-C did not report the incident to administration and said she should have reported the incident. An attempt was made to interview C1 on 5/26/2016, at 3:00 p.m. however, C1 continued to repeat the questions and provided no additional information. Interview with CC-B on 5/27/2016, at 10:04 a.m. established she worked the evening of 3/31/2016. CC-B denied forcing the application of treatment cream to C1's groin. C1 grabbed CC-B's hand during the treatment and she had to repeatedly	W 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G414	A. BUILDING _____ B. WING _____	C 09/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308

(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) COMPLETION DATE
W 153	Continued From page 4 tell the client to let go of her hand. CC-B said C1's behaviors escalated all evening despite attempts by the three staff to distract C1. C1 refused to listen to music, help with laundry, and hit another client on the back. CC-B denied yelling at C1. CC-B said she told C1 to go to his room and followed behind him in the hall. C1 continued to yell and swear and pushed CC-B into a wall. C1 said she tried to calm C1 while in his room but was afraid to let him leave his room. C1 admitted to placing a knife between the doorframe and door preventing C1 from leaving his room. CC-B said C1 responded by pounding on the door but she only left the knife in the doorframe for one to two minutes. C1 did not attempt to leave the room when CC-B removed the knife. CC-B said she knew it was wrong to place the knife in the doorframe but said she had been frustrated with C1 and it was a "stupid mistake." CC-B was placed on suspension pending the results of the investigation and would no longer be working at the facility. Interview with CC-A on 6/1/2016, at 12:17 p.m. established the afternoon of 3/31/2016, she witnessed CC-B speak loudly to C1 very close to his face for repeating comments. CC-A said this was common practice for CC-B. CC-A said CC-B said she would apply C1's treatment cream to his groin. When approached by CC-B, C1 responded with increased agitation and pulling his legs together. CC-B attempted to "pry" C1's legs apart for about two minutes while C1 responded by saying "no" with increased agitation. Despite C1's refusals, CC-B continued with the treatment. Around 7:30 p.m. CC-B told C1 to go to his room and followed behind C1. When C1 entered his room. CC-B immediately shut the door and placed a knife between the doorframe and door	W 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G414	A. BUILDING _____ B. WING _____	C 09/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	**2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308**

(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) COMPLETION DATE
W 153	Continued From page 5 locking C1 in his room. C1 responded by pounding on the door for about ten minutes. The door remained locked for about thirty minutes. CC-A was concerned C1 could hurt himself but CC-B responded by saying "he'll just put on his headset and listen to music." CC-A did not attempt to remove the knife or report the incidents immediately to administration. CC-A said CC-B was a friend which made it difficult to report. Review of the facility's policy and procedure titled Vulnerable Adult Reporting Policy with a review date of 2/1/2011, stated, abuse was defined as conduct which was not an accident or therapeutic conduct that could reasonably produce physical pain or injury or emotional distress. Examples included corporal punishment, use of repeated or malicious oral language toward a vulnerable adult or treatment that could be considered disparaging, derogatory, humiliating, harassing, or threatening. In addition, abuse can be the use of any aversive or deprivation procedures, unreasonable confinement, or involuntary seclusion. The policy revealed a person observing or suspecting maltreatment must immediately verbally report to the program administrator or acting administrator. The program director/coordinator or program administrator will immediately report (within 24 hours) of the initial report to the required state agency.	W 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01684	A. BUILDING: _____ B. WING _____	C 09/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308

(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
5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. A complaint investigation was conducted to investigate case #HG414002. As a result, the following correction orders are issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Supervised Living Facilities. The assigned tag number appears in the far left	5 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01684	A. BUILDING: _____ B. WING _____	C 09/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308

(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
5 000	Continued From page 1 column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." 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/RULES.	5 000		
5 700	MN Statute 144.651 Subd. 14. RES. RIGHTS Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.	5 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01684	A. BUILDING: _____ B. WING _____	C 09/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308

(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
5 700	Continued From page 2 This MN Requirement is not met as evidenced by: Based on document review and interviews, the facility failed to ensure clients were free from abuse for 1 of 3 (C1) clients reviewed when a staff was emotionally and physically abusive. Findings include: Review of the facility's Complaint Report Form dated 4/16/2016, revealed on that date, Consumer Counselor (CC)-A placed a written complaint in the administrative office. The summary indicated on 3/31/3016, during the evening shift, CC-A observed CC-B yelling at C1 nose to nose. In an unspecified amount of time, CC-B told C1 to go to his room and followed behind him. Once C1 entered his room, CC-B shut the door leading to the hallway and placed a knife between the door frame and the door preventing C1 from exiting his room. In addition, earlier in the afternoon, CC-B forcefully pulled C1's legs apart to apply a treatment cream to C1's groin despite C1's verbal refusals. There was no documented injury to C1 following the treatment provided by CC-B. Management did not become aware of the written complaint until 4/18/2016, when CC-A told them the report was hidden on a bookshelf in the office. An interview with the program director (PD) on 5/26/2016, at 1:15 p.m. established on 4/18/2016, no specific time, CC-A informed her that a written complaint alleging staff to client mistreatment had been hidden on a bookshelf in the PD's office. Three staff CC-A, CC-B, and CC-C were working the evening of 3/31/2016. Both CC-C and CC-A witnessed CC-B's treatment of C1 that evening.	5 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01684	A. BUILDING: _____ B. WING _____	C 09/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308

(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
5 700	Continued From page 3 CC-C was a new employee on orientation. Both CC-A and CC-C said CC-B locked C1 in his room by placing a knife between the doorframe and door of C1's room. CC-A said the knife remained in place for about 30 minutes. Also, CC-A reported CC-B forcefully applied C1's groin cream despite his refusals. C1 should have been approached for the treatment later in the shift. Staff have been educated to maintain a safe distance between C1 themselves for safety and to attempt to deescalate C1's behaviors. CC-B should not have been yelling at C1 or close to his face. Attempts to deescalate C1's behaviors should have included contacting the community resource staff to provide staff support or diversional activities such as listening to music which C1's enjoys. CC-B was immediately suspended pending the results of the facility investigation. PD reported the incident the following day to the administrator because she thought the report was required in 24 hours and not immediately as directed by the facility policy. Interview with CC-C on 5/26/2016, at 2:32 p.m. established CC-C was working the evening shift on 3/31/2016, with CC-A and CC-B. Following C1's bath, staff applied treatment cream to C1's groin. CC-C was on orientation and observing the treatment to C1. CC-B was with C1 who was refusing to open his legs and verbally refusing the treatment. CC-B attempted to "pry" open C1's legs to apply the cream. C1 responded by yelling at CC-B and becoming more aggressive. Later that evening CC-C was in another client's room assisting with cares and upon entering the hallway CC-A showed her the knife between the doorframe and door of C1's room. CC-A told her that CC-B placed the knife in the doorframe. CC-C did not report the incident to administration and said she should have reported the incident.	5 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01684	A. BUILDING: _____ B. WING _____	C 09/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308

(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
5 700	Continued From page 4 An attempt was made to interview C1 on 5/26/2016, at 3:00 p.m. however, C1 continued to repeat the questions and provided no additional information. Interview with CC-B on 5/27/2016, at 10:04 a.m. established she worked the evening of 3/31/2016. CC-B denied forcing the application of treatment cream to C1's groin. C1 grabbed CC-B's hand during the treatment and she had to repeatedly tell the client to let go of her hand. CC-B said C1's behaviors escalated all evening despite attempts to distract C1. C1 refused to listen to music, help with laundry, and hit another client on the back. CC-B denied yelling at C1. Finally, CC-B said she told C1 to go to his room and followed behind him in the hall. C1 continued to yell and swear and pushed CC-B into a wall. C1 said she tried to calm C1 while in his room but was afraid to let him leave his room. C1 admitted to placing a knife between the doorframe and door preventing C1 from leaving his room. CC-B said C1 responded by pounding on the door but she only left the knife in the doorframe for one to two minutes. C1 did not attempt to leave the room when the knife was removed. CC-B said she knew it was wrong to place the knife in the doorframe but said she was frustrated with C1 and it was a "stupid mistake." CC-B was placed on suspension pending the results of the investigation and would no longer be working at the facility. Interview with CC-A on 6/1/2016, at 12:17 p.m. established the afternoon of 3/31/2016, she witnessed CC-B raise her voice at C1 very close to his face for repeating comments. CC-A said this was common practice for CC-B. CC-A also witnessed CC-B complete C1's groin treatment.	5 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01684	A. BUILDING: _____ B. WING _____	C 09/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308

(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
5 700	Continued From page 5 Before the treatment, C1 was agitated and pulling his legs together. CC-B attempted to pry C1's legs apart for over two minutes while C1 responded by saying "no". Despite C1's refusals, CC-B continued with the treatment. Around 7:30 p.m. CC-B told C1 to go to his room and followed behind C1. When C1 entered his room. CC-B immediately shut the door and placed a knife between the doorframe and door locking C1 in his room. C1 responded by pounding on the door for about ten minutes. The door remained locked for about thirty minutes. CC-A was concerned C1 could hurt himself but CC-B responded by saying "he'll just put on his headset and listen to music." CC-A did not report the incident immediately to administration. CC-A said CC-B was a friend and it was difficult to report but she knew she should have. Review of the facility's policy and procedure titled Vulnerable Adult Reporting Policy with a review date of 2/1/2011, stated, abuse was defined as conduct which was not an accident or therapeutic conduct that produced or could reasonably produce physical pain or injury or emotional distress. Review of the facility's policy titled The Resident Bill of Rights revised 11/2007 established the client's rights included the right to courteous treatment, the right to be free from isolation and restraint, and the right to refuse care. TIME PERIOD FOR CORRECTION: Twenty One (21) Days.	5 700		
5 815	MN Statute 626.557 Subd. 3. VA Timing of report. (a) A mandated reporter who has reason to	5 815		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01684	A. BUILDING: _____ B. WING _____	C 09/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308

(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
5 815	Continued From page 6 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: (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 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, 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 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	5 815		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01684	A. BUILDING: _____ B. WING _____	C 09/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308

(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
5 815	Continued From page 7 may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure an alleged incident of staff to client mistreatment was reported immediately to the administrator and state agency for 1 of 3 (C1) clients reviewed. Findings include: Observations made on 5/26/2016, at 1:46 p.m. revealed all of the client's bedrooms were located in one common hallway. C1's bedroom was located near the main living area of the house. C1's bedroom door opened out into the hallway. On 4/20/2016, the state agency received a report of alleged staff physical and verbal abuse of C1 that occurred on 3/31/2016. Review of C1's medical record indicated he was admitted to the facility on 2/23/2005, with diagnoses that included severe intellectual disability, microcephaly, idiopathic growth hormone deficiency or short stature, and disruptive behaviors. Review of C1's Comprehensive Functional Assessment dated 5/13/2016, revealed C1 was independent in all areas of transfers and mobility. C1 required minimal assistance from staff for all activities of daily living (ADL)'s and was able to communicate his needs to staff. C1 required staff assistance with medication administration and skin treatments.	5 815		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01684	A. BUILDING: _____ B. WING _____	C 09/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308

(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
5 815	Continued From page 8 Review of C1's Self-Management Assessment dated 5/13/2016, revealed C1 had a formal behavioral plan developed by a community resource. Review of C1's Active Treatment Program Plan revised on 8/15, and 5/16, revealed C1's target behaviors included physical aggression, inappropriate or unwanted behaviors such as repeating phrases, and verbal aggression. The program plan directed staff during episodes of target behaviors, to provide C1 with one short and specific verbal prompt informing him the behavior was inappropriate. If the behaviors continued, staff prompted C1 to leave the immediate area. No further attention was to be given to C1 until he no longer engaged in the target behavior. With aggression, staff reminded C1 to calm in order to be safe. When C1 engaged in socially appropriate behavior, staff were to praise C1 with specific feedback. In addition, frequently throughout the day, staff were to praise C1 for positive behaviors. Review of the facility's Complaint Report Form dated 4/16/2016, revealed on that date, Consumer Counselor (CC)-A placed a written complaint in the administrative office. The summary indicated on 3/31/3016, during the evening shift, CC-A observed CC-B yelling at C1 nose to nose. In an unspecified amount of time, CC-B told C1 to go to his room and followed behind him. Once C1 entered his room, CC-B shut the door leading to the hallway and placed a knife between the door frame and the door preventing C1 from exiting his room. In addition, earlier in the afternoon, CC-B forcefully pulled C1's legs apart to apply a treatment cream to C1's groin despite C1's verbal refusals. There	5 815		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01684	A. BUILDING: _____ B. WING _____	C 09/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308

(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
5 815	Continued From page 9 was no documented injury to C1 following the groin treatment provided by CC-B. Management did not become aware of the written complaint until 4/18/2016, when CC-A told them the written report was hidden on a bookshelf in the office. An interview with the program director (PD) on 5/26/2016, at 1:15 p.m. established on 4/18/2016, no specific time, CC-A informed her that a written complaint alleging staff to client mistreatment had been hidden on a bookshelf in the PD's office. Three staff CC-A, CC-B, and CC-C were working the evening of 3/31/2016. CC-C was a new employee on orientation. Both CC-A and CC-C said CC-B locked C1 in his room by placing a knife between the doorframe and door of C1's room. C1 was unable to exit his room with the knife in place. CC-A said the knife remained in place for about 30 minutes. Also, CC-A reported CC-B forcefully applied a treatment cream to C1's groin despite his refusals. C1 should have approached the client to do the treatment later in the shift. Staff have been educated to keep a distance between C1 and themselves for safety and to attempt to deescalate C1's behaviors. CC-B should not have been yelling at C1 or close to his face. Attempts to deescalate C1's behaviors should have included contacting the community resource staff to provide staff support or diversional activities such as listening to music which C1's enjoys. CC-B was immediately suspended pending the results of the facility investigation. PD reported the incident the following day to the administrator because she thought the report was required in 24 hours and not immediately as directed by the facility policy. PD said CC-B would no longer be employed at the facility. Interview with CC-C on 5/26/2016, at 2:32 p.m.	5 815		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01684	A. BUILDING: _____ B. WING _____	C 09/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308

(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
5 815	Continued From page 10 established CC-C was working the evening shift on 3/31/2016, with CC-A and CC-B. Between 3:00 and 4:00 p.m. following C1's bath, CC-C witnessed CC-B apply an ointment to C1's groin. CC-C was on orientation and observing the treatment to C1. CC-B was inpatient with C1 who was refusing to open his legs and verbally refusing the treatment. CC-B attempted to "pry" open C1's legs for about two minutes to apply the cream. C1 responded by yelling "no" at CC-B and becoming more aggressive. Later that evening CC-C was in another client's room assisting with cares and upon entering the hallway CC-A showed her the knife between the doorframe and door of C1's room. CC-A told CC-C that CC-B place the knife in C1 doorway. CC-C observed the knife in the doorframe for about ten minutes. CC-C did not report the incident to administration and said she should have reported the incident. An attempt was made to interview C1 on 5/26/2016, at 3:00 p.m. however, C1 continued to repeat the questions and provided no additional information. Interview with CC-B on 5/27/2016, at 10:04 a.m. established she worked the evening of 3/31/2016. CC-B denied forcing the application of treatment cream to C1's groin. C1 grabbed CC-B's hand during the treatment and she had to repeatedly tell the client to let go of her hand. CC-B said C1's behaviors escalated all evening despite attempts by the three staff to distract C1. C1 refused to listen to music, help with laundry, and hit another client on the back. CC-B denied yelling at C1. Finally, CC-B said she told C1 to go to his room and followed behind him in the hall. C1 continued to yell and swear and pushed CC-B into a wall. C1 said she tried to calm C1 while in his room but was afraid to let him leave his room. C1 admitted	5 815		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01684	A. BUILDING: _____ B. WING _____	C 09/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308

(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
5 815	Continued From page 11 to placing a knife between the doorframe and door preventing C1 from leaving his room. CC-B said C1 responded by pounding on the door but she only left the knife in the doorframe for one to two minutes. C1 did not attempt to leave the room when CC-B removed the knife. CC-B said she knew it was wrong to place the knife in the doorframe but said she had been frustrated with C1 and it was a "stupid mistake." Interview with CC-A on 6/1/2016, at 12:17 p.m. established the afternoon of 3/31/2016, she witnessed CC-B speak loudly to C1 very close to his face for repeating comments. CC-A said this was common practice for CC-B. CC-A said CC-B said she would apply C1's treatment cream to his groin. When approached by CC-B, C1 responded with increased agitation and pulling his legs together. CC-B attempted to "pry" C1's legs apart for about two minutes while C1 responded by saying "no" with increased agitation. Despite C1's refusals, CC-B continued with the treatment. Around 7:30 p.m. CC-B told C1 to go to his room and followed behind C1. When C1 entered his room. CC-B immediately shut the door and placed a knife between the doorframe and door locking C1 in his room. C1 responded by pounding on the door for about ten minutes. The door remained locked for about thirty minutes. CC-A was concerned C1 could hurt himself but CC-B responded by saying "he'll just put on his headset and listen to music." CC-A did not attempt to remove the knife or report the incidents immediately to administration. CC-A said CC-B was a friend which made it difficult to report. Review of the facility's policy and procedure titled Vulnerable Adult Reporting Policy with a review date of 2/1/2011, stated, abuse was defined as	5 815		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01684	A. BUILDING: _____ B. WING _____	C 09/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308

(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
5 815	Continued From page 12 conduct which was not an accident or therapeutic conduct that could reasonably produce physical pain or injury or emotional distress. Examples included corporal punishment, use of repeated or malicious oral language toward a vulnerable adult or treatment that could be considered disparaging, derogatory, humiliating, harassing, or threatening. In addition, abuse can be the use of any aversive or deprivation procedures, unreasonable confinement, or involuntary seclusion. The policy revealed a person observing or suspecting maltreatment must immediately verbally report to the program administrator or acting administrator. The program director/coordinator or program administrator will immediately report (within 24 hours) of the initial report to the required state agency. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 815		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
24G414	A. Building B. Wing	10/28/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix W0153 Reg. # 483.420(d)(2) LSC	Correction Completed 10/28/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) LK/mm	DATE 10/28/2016	SIGNATURE OF SURVEYOR 20784	DATE 10/28/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/13/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
01684 Y1	A. Building B. Wing Y2	10/28/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEWOOD HOME	2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 50700 Reg. # MN Statute 144.651 Subd. 14. LSC	Correction Completed 10/28/2016	ID Prefix 50815 Reg. # MN Statute 626.557 Subd. 3. LSC	Correction Completed 10/28/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) LK/mm	DATE 10/28/2016	SIGNATURE OF SURVEYOR 20784	DATE 10/28/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/13/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO