

Office of Health Facility Complaints Investigative Report

Facility Name: Prairiewood Home		Report Number: HG414002	Date of Visit: May 26, 2016	
Facility Address: 2736 LeHomme Di	eu Heights NE		Time of Visit: 11:00 a.m3:30 p.m.	Date Concluded: January 26, 2017
Facility City: Alexandria			Investigator's Name and Jill Hagen, RN	d Title:
State: Minnesota	ZIP: 56308	County: 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)
- |X| 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

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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): ☐ Financial Exploitation ☐ Neglect ☐ Inconclusive based on the following information: ☐ Not Substantiated **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 ☐ Neglect ☐ Financial Exploitation. This determination was based on the following: Abuse 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

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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

[&]quot;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

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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:

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

Other pertinent medical records:

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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:									
Did you interview additional residents? No									
Total number of resident interviews:Two									
Interview with staff: 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: Date: Time: Date: Time: Time: O 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 \bigcirc No N/A Was equipment being operated in safe manner: Yes O No N/A Were photographs taken: O 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**

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PRINTED: 09/13/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		24G414	B. WING	à		00	C	
	PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE 2736 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308	1 09	<u>/13/2016</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIESE OF THE APPRO) BE	(X5) COMPLETION DATE	
W 000	INITIAL COMMENT	-S	w	000				
W 153	investigate case #H following deficiency 483.420(d)(2) STAF The facility must en mistreatment, negle injuries of unknown immediately to the a	sure that all allegations of ect or abuse, as well as source, are reported administrator or to other ce with State law through	W	153				
	This STANDARD is Based on observation interview, the facility incident of staff to observe interview incident of staff to observe incident of staff to observe include: Observations made revealed all of the observe incident of alleged staff phys that occurred on 3/3 medical record indicality on 2/23/2005 severe intellectual dispersations.	on, document review and railed to ensure an alleged ient mistreatment was y to the administrator and f 3 (C1) clients reviewed. on 5/26/2016, at 1:46 p.m. ient's bedrooms were located way. C1's bedroom was in living area of the house. opened out into the hallway. tate agency received a report ical and verbal abuse of C1 1/2016. Review of C1's ated he was admitted to the with diagnoses that included isability, microcephaly,						
	stature, and disruptiv	rmone deficiency or short re behaviors. Review of C1's ctional Assessment dated						
ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE		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 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION ING	(X	(X3) DATE SURVEY COMPLETED		
		24G414	B. WING			C 09/13/2016	
NAME OF PROVIDER OR SUPPLIER PRAIRIEWOOD HOME				STREET ADDRESS, CITY, STATE, ZIP 2736 LEHOMME DIEU HEIGHTS N ALEXANDRIA, MN 56308		09/13/2016	
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	5/13/2016, revealed areas of transfers a minimal assistance daily living (ADL)'s a his needs to staff. Owith medication adritreatments. Review of C1's Self dated 5/13/2016, rebehavioral plan devresource. Review of C1's Active revised on 8/15, and behaviors included pinappropriate or unverseating phrases, a program plan direct target behaviors, to specific verbal promwas inappropriate. It staff prompted C1 to No further attention no longer engaged i aggression, staff rerbe safe. When C1 eappropriate behaviors. Review of the facility dated 4/16/2016, revenumer Counseld complaint in the admisummary indicated devening shift, CC-Active daily constitute the day and the day	In C1 was independent in all and mobility. C1 required from staff for all activities of and was able to communicate in required staff assistance ministration and skin. -Management Assessment vealed C1 had a formal eloped by a community. We Treatment Program Plant of 5/16, revealed C1's target ohysical aggression, wanted behaviors such as and verbal aggression. The eld staff during episodes of provide C1 with one short and pt informing him the behavior of the behaviors continued, of leave the immediate area, was to be given to C1 until he in the target behavior. With minded C1 to calm in order to ingaged in socially restaff were to praise C1 with a addition, frequently staff were to praise C1 for	W 1	53			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
		24G414	B. WING			C	
	NAME OF PROVIDER OR SUPPLIER PRAIRIEWOOD HOME			STREET ADDRESS, CITY, STATE, Z 2736 LEHOMME DIEU HEIGHTS ALEXANDRIA, MN 56308		09/13/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE	
W 153	CC-B told C1 to go behind him. Once C shut the door leading knife between the dispreventing C1 from earlier in the afternorm C1's legs apart to a C1's groin despite C was no documented groin treatment provided not become away until 4/18/2016, who report was hidden on An interview with the 5/26/2016, at 1:15 puno specific time, CC complaint alleging sheen hidden on a both Three staff CC-A, Complete the evening of 3/31/employee on oriental said CC-B locked C knife between the directory complete his refusion despite his refusion de	to his room and followed C1 entered his room, CC-B ag to the hallway and placed a door frame and the door exiting his room. In addition, con, CC-B forcefully pulled pply a treatment cream to C1's verbal refusals. There in dinjury to C1 following the vided by CC-B. Management are of the written complaint en CC-A told them the written on a bookshelf in the office. The program director (PD) on c.m. established on 4/18/2016, C-A informed her that a written at the first to client mistreatment had bookshelf in the PD's office. CC-B, and CC-C were working 2016. CC-C was a new action. Both CC-A and CC-C in his room by placing a coorframe and door of C1's let to exit his room with the asaid the knife remained in minutes. Also, CC-A reported lied a treatment cream to C1's usals. C1 should have not to do the treatment later in been educated to keep a 1 and themselves for safety rescalate C1's behaviors. We been yelling at C1 or close	W 1	53			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		24G414	B. WING		_		C 13/2016	
PRAIRIEWOOD HOME				STREET ADDRESS, CITY, ST. 2736 LEHOMME DIEU HEI ALEXANDRIA, MN 5630	GHTS NE	<u>1 03</u> /	13/2010	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD ID TO THE APPROPE (CIENCY)	BE	(X5) COMPLETION DATE	
	suspended pending investigation. PD refollowing day to the thought the report was possible to said CC-B would the facility. Interview with CC-C established CC-C was on 3/31/2016, with C3:00 and 4:00 p.m. witnessed CC-B app CC-C was on orient treatment to C1. CC refusing to open his treatment. CC-B attelegs for about two mare responded by yelling more aggressive. La another client's room upon entering the has knife between the doroom. CC-A told CC in C1 doorway. CC-C doorframe for about report the incident to should have reported. An attempt was made 5/26/2016, at 3:00 perpeat the questions information. Interview with CC-B established she work CC-B denied forcing.	the results of the facility ported the incident the administrator because she was required in 24 hours and directed by the facility policy. It does not longer be employed at a son 5/26/2016, at 2:32 p.m. as working the evening shift acc-A and CC-B. Between following C1's bath, CC-C ally an ointment to C1's grain. Act at a solid part of the sempted to "pry" open C1's allow as legs and verbally refusing the empted to "pry" open C1's allow at CC-B and becoming after that evening CC-C was in assisting with cares and allway CC-A showed her the conframe and door of C1's allow according to the knife cobserved the knife in the ten minutes. CC-C did not administration and said she did the incident. The second of th	W 1	53				
	during the treatment	C1 grabbed CC-B's hand and she had to repeatedly						

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		24G414	B. WING		00	C 9 /13/2016
NAME OF PROVIDER OR SUPPLIER PRAIRIEWOOD HOME				STREET ADDRESS, CITY, STATE, ZIF 2736 LEHOMME DIEU HEIGHTS I ALEXANDRIA, MN 56308	CODE	13/2010
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W 153	tell the client to let of behaviors escalated by the three staff to listen to music, help client on the back. CC-B said she told followed behind him yell and swear and said she tried to cal was afraid to let him to placing a knife be door preventing C1 said C1 responded she only left the knift two minutes. C1 did when CC-B remove knew it was wrong t doorframe but said C1 and it was a "stuplaced on suspension investigation and wo the facility. Interview with CC-A established the after witnessed CC-B spenis face for repeatin was common practic said she would apply groin. When approa with increased agita together. CC-B atterfor about two minutes saying "no" with increased for about two minutes saying "no" with increased agita together. CC-B conticuted and followed behind room. CC-B immediates.	ge 4 go of her hand. CC-B said C1's d all evening despite attempts distract C1. C1 refused to with laundry, and hit another CC-B denied yelling at C1. C1 to go to his room and in the hall. C1 continued to pushed CC-B into a wall. C1 m C1 while in his room but leave his room. C1 admitted atween the doorframe and from leaving his room. CC-B by pounding on the door but fe in the doorframe for one to not attempt to leave the room d the knife. CC-B said she o place the knife in the she had been frustrated with pid mistake." CC-B was on pending the results of the build no longer be working at con 6/1/2016, at 12:17 p.m. moon of 3/31/2016, she sak loudly to C1 very close to g comments. CC-A said this ce for CC-B. CC-A said CC-B y C1's treatment cream to his ched by CC-B, C1 responded tion and pulling his legs mpted to "pry" C1's legs apart as while C1 responded by eased agitation. Despite C1's nued with the treatment. C-B told C1 to go to his room C1. When C1 entered his ately shut the doorframe and door the doorframe and doo	W 1	53		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		24G414					С	
NAME OF	PROVIDER OR SUPPLIER	249414	B. WING			09/	13/2016	
	WOOD HOME			STREET ADDRESS, CITY, STATE, 2736 LEHOMME DIEU HEIGHT ALEXANDRIA, MN 56308				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE	
W 153	locking C1 in his ropounding on the do door remained lock CC-A was concerned CC-B responded by headset and listen that attempt to remove the incidents immediated said CC-B was a fristerport. Review of the facility Vulnerable Adult Redate of 2/1/2011, state conduct which was conduct that could repain or injury or emplications or all language or treatment that condisparaging, derogation or treatment that condisparaging, derogation or injury or emplications or all languages or threatments. In according a derogation of any aversive or dunreasonable confirms seclusion. The policy revealed suspecting maltreat verbally report to the acting administrator director/coordinator	om. C1 responded by or for about ten minutes. The ed for about thirty minutes. Ed C1 could hurt himself but a saying "he'll just put on his to music." CC-A did not the knife or report the ely to administration. CC-A end which made it difficult to by's policy and procedure titled eporting Policy with a review eated, abuse was defined as not an accident or therapeutic reasonably produce physical potional distress. Examples unishment, use of repeated or large toward a vulnerable adult uld be considered atory, humiliating, harassing, addition, abuse can be the use eprivation procedures, hement, or involuntary a person observing or ment must immediately exprogram administrator or. The program or program administrator will within 24 hours) of the initial	W	153				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING 01684 09/13/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2736 LEHOMME DIEU HEIGHTS NE PRAIRIEWOOD HOME **ALEXANDRIA, MN 56308** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 5 000 Initial Comments 5 000 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.

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

The assigned tag number appears in the far left

TITLE

(X6) DATE

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ 01684 B. WING 09/13/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2736 LEHOMME DIEU HEIGHTS NE **PRAIRIEWOOD HOME** ALEXANDRIA, MN 56308 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 5 000 Continued From page 1 5 000 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. 5 700 MN Statute 144.651 Subd. 14. RES. RIGHTS 5 700 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

Minnesota Department of Health

others.

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ С B. WING 01684 09/13/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2736 LEHOMME DIEU HEIGHTS NE **PRAIRIEWOOD HOME** ALEXANDRIA, MN 56308 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 5 700 Continued From page 2 5 700 This MN Requirement is not met as evidenced 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

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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.

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING 01684 09/13/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2736 LEHOMME DIEU HEIGHTS NE **PRAIRIEWOOD HOME ALEXANDRIA, MN 56308** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 5 700 Continued From page 3 5 700 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.

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CC-C did not report the incident to administration and said she should have reported the incident.

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ COMPLETED С 01684 B. WING 09/13/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2736 LEHOMME DIEU HEIGHTS NE PRAIRIEWOOD HOME ALEXANDRIA, MN 56308 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 5 700 Continued From page 4 5 700 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

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this was common practice for CC-B. CC-A also witnessed CC-B complete C1's groin treatment.

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 01684 09/13/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2736 LEHOMME DIEU HEIGHTS NE **PRAIRIEWOOD HOME** ALEXANDRIA, MN 56308 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRFFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 5 700 Continued From page 5 5 700 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.

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5 815 MN Statute 626.557 Subd. 3. VA Timing of report.

(a) A mandated reporter who has reason to

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FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ COMPLETED C B. WING 01684 09/13/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2736 LEHOMME DIEU HEIGHTS NE **PRAIRIEWOOD HOME ALEXANDRIA, MN 56308** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 5 815 Continued From page 6 5 815 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,

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paragraph (c), clause (5), the reporter or facility

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING 01684 09/13/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2736 LEHOMME DIEU HEIGHTS NE PRAIRIEWOOD HOME **ALEXANDRIA, MN 56308** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 5 815 Continued From page 7 5 8 1 5 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 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

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treatments.

with medication administration and skin

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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

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NAME OF PROVIDER OR SUPPLIER PRAIRIEWOOD HOME 2738 LEHOMME DIEU HEIGHTS NE ALEXANDRIA, MN 56308 XMM		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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SUMMAPY STATEMENT OF DEPOSICATION PROVIDER'S PLAN OF CORRECTION PRICE PRICE	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE				
PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) 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 3/18/2016. 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 desecalate C1's behaviors. CC-B should not have been yelling at C1 or close to his face. Attempts to deescalate C1's behaviors. C-B 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	PRAIRIE	WOOD HOME							
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 not long policy at the callity policy.	PRÉFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETE		
Interview with CC-C on 5/26/2016, at 2:32 p.m.	5 815	was no documented groin treatment provided not become awa until 4/18/2016, whe report was hidden of An interview with the 5/26/2016, at 1:15 pushes possible time, CC complaint alleging signature been hidden on a both the evening of 3/31/employee on oriental said CC-B locked Counties between the document of the said CC-B locked Counties and the complete his refugition of the shift. Staff have distance between Counties and to attempt to de CC-B should not have to his face. Attempts behaviors should have community resource or diversional activities which C1's enjoys. On the substitution of the substitution. PD reprocession of the substitution of the substitutio	d injury to C1 following the vided by CC-B. Management are of the written complaint on CC-A told them the written in a bookshelf in the office. The program director (PD) on o.m. established on 4/18/2016, cA informed her that a written taff to client mistreatment had bookshelf in the PD's office. The program director (PD) on o.m. established on 4/18/2016, cA informed her that a written taff to client mistreatment had bookshelf in the PD's office. The program director (PD) on o.m. established on 4/18/2016, cA informed her that a written taff to client mistreatment had bookshelf in the PD's office. The program director (PD) on o.m. established on 4/18/2016, cA informed her that a written taff to client mistreatment had on 4/18/2016, cA informed her that a new architectors are directly beautiful to exist the said the knife remained in oninutes. Also, CC-A reported ied a treatment cream to C1's usals. C1 should have not to do the treatment later in been educated to keep a of the treatment later in the educated to keep a of the treatment later in the educated to keep a of the said the provide staff support estaff to provide staff support estaff support estaff to provide staff support estaff su	5 815					

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was afraid to let him leave his room. C1 admitted

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED 01684 B. WING 09/13/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2736 LEHOMME DIEU HEIGHTS NE PRAIRIEWOOD HOME **ALEXANDRIA, MN 56308** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 5 815 Continued From page 11 5 815 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 saving "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

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report.

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

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

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ C B. WING 01684 09/13/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2736 LEHOMME DIEU HEIGHTS NE **PRAIRIEWOOD HOME** ALEXANDRIA, MN 56308 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 5 815 Continued From page 12 5 815 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.

Minnesota Department of Health

STATE FORM

			POST	-CERTIFIC	CATION	REVISIT R	EPORT			
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	WOOD HOME				1	STREET ADDRESS, CIT 2736 LEHOMME DIEU F) L		
						ALEXANDRIA, MN 5630				
program, corrected provision	to show those I and the date s	deficiencies p such correctiv	oreviously repo e action was a	orted on the CMS-: accomplished. Eac	2567, Stateme ch deficiency s	d/or Clinical Laborato nt of Deficiencies and hould be fully identific 67 (prefix codes sho	d Plan of Correction	on, that have	rtsc	
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FOLLOWU 9/13/2016	P TO SURVEY C	OMPLETED O	N	CHECK FOR UNCORREC	ANY UNCORR	ECTED DEFICIENCIES CIES (CMS-2567) SENT	. WAS A SUMMARY TO THE FACILITY	OF ?	YES	□ NO
				· · · · · · · · · · · · · · · · · · ·						

Form CMS - 2567B (09/92) EF (11/06)

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EVENT ID: ETSE12

STATE FORM: REVISIT REPORT PROVIDER / SUPPLIER / CLIA / MULTIPLE CONSTRUCTION DATE OF REVISIT **IDENTIFICATION NUMBER** A. Building 01684 B. Wing 10/28/2016 Υ3 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 DATE ITEM DATE ITEM DATE Y4 Y5 **Y4** Y5 Y4 Y5 ID Prefix 50700 Correction **ID Prefix** 50815 Correction **ID Prefix** Correction MN Statute 144,651 MN Statute 626.557 Reg. # Completed Reg. # Subd. 14. Completed Reg.# Subd. 3. Completed LSC 10/28/2016 LSC 10/28/2016 LSC **ID Prefix** Correction **ID Prefix** Correction **ID Prefix** Correction Reg.# Completed Reg. # Completed Reg. # Completed LSC LSC LSC **ID Prefix** Correction **ID Prefix** Correction **ID Prefix** Correction Reg.# Completed Reg. # Completed Reg. # Completed LSC LSC LSC **ID Prefix** Correction **ID Prefix** Correction **ID Prefix** Correction Reg.# Completed Reg.# Completed Reg. # Completed LSC LSC LSC **ID Prefix** Correction **ID Prefix** Correction **ID** Prefix Correction Reg. # Completed Reg.# Completed Reg. # Completed LSC LSC LSC REVIEWED BY **REVIEWED BY** DATE SIGNATURE OF SURVEYOR DATE (INITIALS) LK/mm STATE AGENCY X 10/28/2016 20784 10/28/2016 **REVIEWED BY REVIEWED BY** DATE TITLE DATE CMS RO (INITIALS) FOLLOWUP TO SURVEY COMPLETED ON CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? 9/13/2016 ☐ YES ☐ NO

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EVENT ID:

ETSE12