Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL203157824M
Compliance #: HL203154688C

Date Concluded: September 7, 2023

Name, Address, and County of Licensee Investigated:
The Prairie Lodge at Earle Brown
6001 Earle Brown Drive
Brooklyn Center, MN 55430
Hennepin County

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

Evaluator's Name: Brandon Martfeld, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The alleged perpetrator (AP), facility staff, abused a resident when the AP slapped the resident in the face. In addition, the facility neglected the resident when they failed to provide wound care, assistance with eating, and failed to allow the resident to transfer independently or with minimal assistance from staff.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Review of a recorded video showed the AP, contracted hospice staff, lightly touch the resident's face and cheek. No sound can be heard on the video and the resident had no injury from the AP's actions. Although not appropriate treatment, the action did not meet the definition of abuse.

The Minnesota Department of Health determined neglect was not substantiated. Facility staff provided the resident with services according to the resident's assessed and care planned needs.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator contacted family members, hospice leadership, the hospice nurse, and the AP. The investigation included review of medical records, recorded video, and facility policies and procedures. Also, the investigator observed cares provided to the resident without concerns.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with dressing, grooming, bathing, eating, and incontinence care. The resident required two staff and the use of a gait belt for pivot transfers. The resident did not ambulate and used a Broda chair (high back wheelchair) and staff assistance with mobility of the chair. The resident required assistance from others for decision making and staff to anticipate her needs. Staff were directed to provide safety checks every two hours but not to wake the resident during the night when asleep. The resident's service plan included coordination of care with a contracted hospice agency for comfort care.

The resident was a high risk for falls and staff were directed to place a fall matt next to the resident's bed, check on the resident every two hours, and place the bed in a low position to reduce the resident's risk for injury.

The resident had a history of repeatedly yelling "Help me", restlessness during the night, daytime dozing, and resisting care. Staff were directed to approach the resident later, have a second staff complete the resident's care, offer liquids, provide incontinence care, and place the resident in the common area for improved staff supervision, reassurance, and observations.

The facility's progress notes indicated one day; facility leadership was made aware the resident's camera in her room showed an outside contracted hospice staff member (AP) slap the resident. The facility's leadership contacted hospice leadership who had completed an investigation into the incident. Hospice staff reviewed the video and determined the AP did not slap the resident, but with one hand touched the resident's cheek causing her head to turn. The note indicated hospice provided the AP with additional training.

Review of the recorded video showed the resident lying in bed with the AP standing next to the bed facing the resident. The AP, with his right hand quickly moves his hand over the resident cheek and mouth causing the resident's head to turn to the right. No noise can be heard from the AP's actions.

Review of a second video showed the AP in the resident's room four days later. The video showed the back of the resident's Broda chair, with the resident sitting in the wheelchair. The AP when standing behind the wheelchair, placed one hand under each of the resident's arms and pulled the resident into a sitting position. The AP went to face the resident and moved his right hand by the resident's face. The resident moved her head to the right. No sound of a slap was heard on the video.

During an interview, the facility's leadership stated the AP did not work for the facility. The AP worked for a hospice agency. Leadership stated hospice provided services to the resident two to three times a week. The facility's leadership stated the video showed the AP touching the resident's face, but the AP did not slap or hit the resident.

During an interview, hospice leadership stated the resident's family member notified them of an incident between the AP and the resident. Hospice leadership stated they reviewed the recorded video, and the AP did not slap the resident. Facility leadership stated when they became aware of the allegation, the AP was immediately removed from the schedule and before returning to work, required to complete additional training related to caring for residents with dementia.

During an interview, the AP stated one day the resident needed assistances with eating. The resident was resistive in the dining room. Because the resident was agitated, the AP took the resident to her room. The AP stated when the resident was agitated, the AP should have left the resident in a safe position to allow the resident to calm down. The AP denied slapping the resident. The AP stated a few days later, the AP came to see the resident and was told by a family member through the video camera, to leave the room. The AP stated he was initially suspended and completed education prior to returning to work.

During an interview, a family member stated the first video showed the resident and the AP arguing with each other while cares were being completed. The AP tapped the resident on the mouth. Then four days later, the resident and the AP were arguing, and the AP tapped the resident's mouth causing the resident head to turn. The family member stated the AP did not slap the resident.

The allegation also included concerns facility staff neglected the resident when staff failed to assist the resident to eat, failed to provide wound care, failed to allow for the resident to transfer independently, and failed to check on the resident during the night. Staff assisted the resident to eat in the community dining room. Frequently, the resident refused to eat the facility meal and staff provided the resident an alternative food choice. Usually daily, the resident's family brought in an evening meal.

Review of the resident's record indicated the resident had a skin tear on a shin cared for by the hospice staff, one to two times a week. There was no indication of additional wounds or wound care.

Staff assisted the resident with transfers using two staff and a gait belt according to the resident's assessment.

During an interview, the hospice nurse stated the resident often refused to eat the facility meals. The hospice nurse stated facility offered the resident her meal of choice, peanut-butter, and jelly toast. The resident required a mechanical soft diet and had a decline in heath and

apetite. The hospice nurse stated the resident's skin was fragile and thin, prone to bruising and tears.

During an interview, facility leadership stated staff were directed to visually check on the resident during the night by entering the room, and if the resident was asleep, staff were to allow the resident to sleep. Facility leadership said when the resident was restless at night, staff were to place the resident in the common area for staff supervision.

Another concern investigated included the facility had a mice and ant infestation. During the onsite visit, a facility tour was completed, and no mice or ant concerns were observed. The facility leadership stated they had an issue with mice a few months ago, hired an exterminator and had no other issues.

In conclusion, the Minnesota Department of Health determined abuse and neglect were not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No. An attempt was made but unable due to cognitive impairment.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility notified the resident’s family member and notified hospice leadership.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20315	A. BUILDING: _____ B. WING _____	C 08/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRAIRIE LODGE AT EARLE BROWN	6001 EARLE BROWN DRIVE BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments On August 21, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL203157824M/#HL203154688C. No correction orders are issued.	0 000		