Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308091680M
Compliance #: HL308099247C

Date Concluded: September 5, 2024

Name, Address, and County of Licensee Investigated:
Prairie Senior Cottages of Isanti
706 6th Ave NE
Isanti, MN 55040
Isanti County

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

Evaluator's Name: Brandon Martfeld, RN BSN
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 facility neglected the resident when staff failed transfer the resident according to the plan of care causing a fractured left collarbone. In addition, the facility failed to provide the resident with a new mattress when the old mattress was urine soaked and made the resident lay on plastic one night causing a skin rash.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Facility staff transferred the resident according to the resident's assessed and care planned needs. When the resident's mattress became soiled, the facility replaced the mattress. Also, there was no evidence the resident laid on plastic for a night and the resident had a previous skin condition that presented as blisters.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family members

and hospice nurse. The investigation included review of the resident records, facility incident reports, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer disease, urine retention, recurrent urine tract infection, and contact dermatitis (skin rash caused when a substance irritates the skin or an allergic reaction.) The resident's service plan included assistance with transfers, toileting, safety checks, bedding change, morning cares, evening care, was incontinent of bladder, and at risk for falling. The resident required two staff with a mechanical sling lift for transfers and two staff assist for activities of daily living. The resident was moderately cognitively impaired.

One month, the resident complained of shoulder pain. The resident received hospice services and was prescribed medications that relieved the pain. In addition, at the same time the facility changed the resident from a standing lift to a mechanical sling lift for transfers.

About one month later, the resident complained of increased pain in his shoulders not relieved with the current pain medications. An x-ray was completed and revealed a left collarbone fracture. The resident had no previous falls prior to the pain in the shoulders. The provider ordered a sling for the resident's left arm for healing.

During an interview, a nurse stated the resident required two staff for cares and used a mechanical sling lift for transfers. One day the resident complained of increased shoulder pain and an x-ray was ordered. The x-ray revealed the resident's left collarbone was fractured. The nurse stated the facility completed an investigation into the fracture of the resident's collarbone and were not able to determine a cause of the fracture. The nurse stated the resident had fractured the left collarbone in approximately the same area two years earlier. The nurse stated when the resident's mattress became soiled, the facility replaced the mattress. The nurse stated the resident had recurring skin concerns. The resident had been treated for a yeast infection and would get fluid filled blisters randomly on his body. If the blisters opened, the area would be cleansed and treated.

During an interview the resident's family members stated after the fracture was revealed on x-ray, the resident was to wear a sling for his arm. The family members stated the resident's mattress was replaced by the facility. The family members stated the resident's blisters were not new and that the resident had suffered from random blisters for years.

In conclusion, the Minnesota Department of Health determined neglect was 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.

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. Resident resided at a different facility.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility followed up on the resident’s report of increased left shoulder pain, an x-ray was ordered, and an arm sling was ordered for the resident. The resident’s skin was monitored weekly on bath days and treatment provided when needed. The resident’s soiled mattress was replaced with a different mattress.

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
	30809	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SENIOR COTTAGES OF ISANTI LLC	706 6TH AVENUE NE ISANTI, MN 55040

(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 5, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL308091680M/#HL308099247C. No correction orders are issued.	0 000		