Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL322766184M
Compliance #: HL322761668C

Date Concluded: June 27, 2023

Name, Address, and County of Licensee Investigated:
Prelude Homes
4650 White Bear Parkway
White Bear Lake, MN 55110
Ramsey County

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

Evaluator's Name: Katie Germann, RN, Special Investigator

Finding: Substantiated, individual responsibility

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

Initial Investigation Allegation(s):
The alleged perpetrator, (AP) neglected a resident when the AP did not provide necessary cares or safety checks to ensure the resident was safe. The resident was locked out of the building for several hours, sustained a fall, and was unable to call for staff assistance.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP locked the courtyard door in the memory care unit without ensuring all of the residents were in the building. AP1 failed to complete any of the residents required evening cares or safety checks the remainder of the night. The following shift (overnights) discovered the resident outside in the courtyard laying on the concrete and landscaping rock. The resident had been outside over six hours.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigation included review of facility policies and procedures, staff

schedules, employee files, resident medical records, hospital notes, and the facility investigation into the incident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease. The resident's service plan included assistance with every two-hour safety check on the odd hours, dressing, grooming, toileting, bathing, meals, eating, medication management, housekeeping, and laundry. The resident was able to make her basic needs known but required the assistance of others for decision making. The resident had impaired balance when standing and walking and ambulated independently with the use of a walker.

The resident's vulnerabilities included a risk for wandering and elopement. The resident required frequent staff monitoring due to the resident's inability to use a call system to request staff assistance.

A facility investigation of the incident indicated the facility recorded video was reviewed and the resident was observed with the AP, the resident's assigned caregiver for the evening shift, going out onto the facility patio [courtyard]. The AP left the resident outside and returned inside. Three minutes later, the resident returned inside and was seen inside by facility staff. Five minutes later, approximately 6:50 p.m., the resident went back out onto the patio which appeared to be unwitnessed by any staff.

According to the resident's service record, (where staff document the resident cares they complete) the AP documented completing two safety checks on the resident that evening and assisted her with night-time cares and toileting before the end of his shift at 11:00 p.m. The AP documented the residents 7:00 p.m. safety check was completed at 3:35 p.m., and the 9:00 p.m. safety check was completed at 7:24 p.m. The 11:00 p.m. safety check was recorded by the next shift as "not done" with no explanation.

Over six hours since the resident had last been seen on the facility recorded video going outside, the overnight staff completed the required resident safety check, and the resident was not in her room. The staff searched for the resident and heard the resident calling for help from the outside courtyard. The resident was found at approximately 1:45 a.m. lying on the concrete patio with her head lying partially on the landscaping rock. The resident complained of left leg pain and was sent to the hospital for further evaluation.

Hospital notes indicated the resident had a fall and tests were completed to rule out any injuries. The resident was diagnosed with a urinary tract infection and discharged back to the facility with oral antibiotics.

During interview the administrator stated the courtyard was enclosed and secured with a locked gate. During the day, the doors are unlocked for residents to go outside. Staff lock the doors around 8:00 p.m. and are trained to check outside for any resident in the courtyard prior

to locking the doors. The administrator stated the safety check at shift change should be done by the oncoming and outgoing staff to report off on each resident.

When interviewed the AP stated he assisted the resident in from the patio and the resident went to her room. The AP stated he did not see the resident the rest of the shift. The AP stated he did go to the resident's room and her door was locked so he thought she was inside her room. The AP did not go into the resident's room to complete safety checks or assist the resident with the assigned evening cares. AP1 stated he did not go on the patio to ensure all the residents were inside that evening before locking the door because he did not have time.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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, due to cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated the incident and sent the resident to the hospital. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney
White Bear Lake City Attorney
White Bear Lake Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32276	A. BUILDING: _____ B. WING _____	C 04/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRELUDE HOMES & SERVICES LLC	4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL322769138C/ HL322765323M #HL322761521C/#HL322766064M #HL322761668C/#HL322766184M On April 18, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 30 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL322761521C/#HL322766064M, and #HL322761668C/#HL322766184M, tag identification 2310, and 2360.	0 000	The Minnesota Department of Health documents the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the Surveyors and/or Investigators ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the state correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys and/or complaint investigations. 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.	

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0 000	Continued From page 1	0 000	THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPY AND LEVEL ISSUED PURSUANT TO THE MINN. STAT. § 144G.31, SUBDIVISION 2 and 3.	
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure assisted living services were provided based on the resident's needs and subject to accepted health care standards for one of one resident (R1) with a fall with leg injury, and one of one resident (R2) who was locked outside the facility for over six hours. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1	02310		

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02310	Continued From page 2 R1's 90-day assessment dated August 30, 2022 indicated the resident had diagnoses of dementia and a history of falls. R1 received assistance with dressing, bathing, grooming, meals, medications, laundry, and housekeeping. R1's service plan directed staff to complete safety checks every two hours, and assist the resident with toileting two times overnight. The assessment indicated R1 was able to transfer on her own and did not use a wheelchair for mobility. R1's most recent assessment dated April 12, 2023, indicated the resident had impaired judgement and difficulty communicating. A facility document titled, "incident report", dated April 6, 2023, indicated R1 had an unwitnessed fall at approximately 9:00 p.m. The report indicated the resident had no pain, and the nurse was notified. A facility report dated April 7th, 2023, titled, Investigation for R1's incident on April 6, 2023, indicated the facility camera footage was reviewed of R1's fall. At 8:57 p.m. on April 6, 2023, R1 was observed landing on her bottom with her right leg pinned beneath her. R1 removed her right leg from underneath herself. R1 was observed rubbing her right leg. At approximately 9:00 p.m., unlicensed personnel (ULP)-F found the resident on the floor and ULP-E came to assist ULP-F to lift R1 off the floor. R1 was visibly unable to bear weight, so ULP-F and ULP-E assisted R1 to the nearest chair and obtained a wheelchair to bring R1 to her room. The taped camera footage in R1's room from April 6, 2023, at 9:06 p.m. was reviewed. ULP-F	02310		

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02310	Continued From page 3 and ULP-E brought R1 into her room in a wheelchair. ULP-F and ULP-E attempted to transfer R1 from the wheelchair to her bed. When R1 stood up she was grunting and saying, "no, no!" R1 did not appear to move her right leg during the transfer as ULP-F and ULP-E attempted to pivoted the resident to sit on the edge of the bed. As R1 continued to groan and and state, "No, no," ULP-E continued to repeat to R1, "You're fine". R1 was sitting on the edge of the bed and ULP-E grabbed R1's legs and lifted them into bed. R1 cried out and moaned.. ULP-F continued to repeat to R1, "You're fine." When R1 was laying in bed ULP-E touched and rubbed R1's right leg and told ULP-F, "come see her [R1] foot", ULP-F asked ULP-E if R1's right leg, "feel weird?" While ULP-F and ULP-E were looking at R1's leg, R1 propped herself up on her elbows and stated, "it's bad". ULP-E was observed taking a cellular phone out and taking a picture of R1's leg. R1 attempted to sit up in bed and ULP-F and ULP-E both told the resident she needed to stay laying down. ULP-F stated, "You can't walk on that leg, you're going to fall down." ULP-F and ULP-E continued to discuss what to do while R1 continued to attempt to sit up in bed. ULP-F sat on the edge of R1's bed next to the resident and continued to rub R1's right leg and ULP-E left R1's room. ULP-F lifted both of R1's legs straight into bed so R1 was lying flat. R1 was moaning during the move. ULP-F left R1's room. R1's nurses' notes dated April 6, 2023, at 9:47 p.m. indicated the nurse was notified of an unwitnessed fall with "no injuries, no head strike, no reports of pain. R1's range of motion and vital signs were stable and indicated staff would continue to monitor R1. R1's progress notes written by ULP-F and dated	02310		

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02310	Continued From page 4 April 6, 2023 at 8:10 p.m. stated R1, "ate her dinner well and took her meds." There was no documention regarding R1's fall. The overnight notes documented by ULP-D on April 7, 2023 at 6:52 a.m., indicated R1 "slept well during the night shift and staff checked on her every two hours during rounds and staff assisted her with toileting, resident did not have a bowel movement, no complaints, no behaviors, no pain". ULP-D documented R1 was assisted to the bathroom three times on her shift. R1's nurses' notes dated April 7, 2023, at 9:06 a.m., indicated, "Received report that resident [R1] complained of pain in right leg, unable to stand up. Right shin appears different, almost bow, per staff. Resident had an unwitnessed fall last evening but did not have injury per report." The nurses notes indicated R1 was sent to the hospital via ambulance and family was notified. When interviewed on April 25, 2023, at 9:13 a.m., ULP-F stated she assisted R1 off the floor following the fall. ULP-F stated she could not tell if R1 was in pain or if the residents leg looked any different than normal. ULP-F stated R1 was transferred to her room with a wheelchair after the fall because R1 was unable to stand. ULP-F stated she did not see R1 after she assisted the resident to bed following the fall. During an interview on April 26, 2023, at 9:59 a.m., ULP-E stated she assisted R1 off the floor following the fall. ULP-E stated R1 started crying when they were trying to lift her off the floor, however, ULP-E stated she didn't think anything was different because R1 "cried often." ULP-E stated ULP-F obtained a wheelchair to transfer R1 to her room because R1 was unable to stand.	02310		

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02310	Continued From page 5 ULP-E stated she called the nurse to report R1's fall but did not tell the nurse about R1's leg or her inability to stand. ULP-E stated she took a picture of R1's leg but did not send it to the nurse. ULP-E stated she sent the picture to a facility manager who was not the facility nurse. During interview on April 26, 2023, at 3:30 p.m., ULP-D stated she was not aware R1 had a fall earlier that evening. ULP-D stated she completed safety checks on R1 every 2 hours overnight, however, she did not toilet R1. ULP-D stated R1 was quiet all night. R1's hospital notes dated April 12, 2023, indicated R1 had fractures to her right tibia and fibula (lower leg bones), and second-fourth metatarsal (foot bones) fractures to her right foot. The hospital notes indicated the orthopedic doctor recommended nonoperative management related to R1's multiple medical conditions. R1 was admitted to hospice and sent back to the facility on April 12, 2023. R1 passed away from her injuries April 18, 2023. During an interview on April 25, 2023, at 9:52 a.m. RN-C stated she was contacted by ULP-E on April 6, 2023, and notified R1 had a fall. RN-C stated ULP-E reported R1 was found on the floor after having an unwitnessed fall. ULP-E reported R1 had no injuries, no pain, did not hit her head, and R1's vital signs and range of motion were normal. During interview on April 19, 2023, at 1:00 p.m, RN-B stated she was the on call nurse the morning following R1's fall. RN-B stated a staff member went to complete morning cares on R1 and the resident, "appeared to be in pain," and the resident was not moving as she usually did.	02310		

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02310	Continued From page 6 During an interview on April 28, 2023, at 11:09 a.m., R1's family member (FM) stated they viewed the camera footage from R1's room after R1's fall on April 6th and throughout the night of April 7th. The family member stated the camera in the residents room turns on and starts recording with any motion or when the door to the room is opened. The recorded video indicated after the fall, R1's door was opened slightly around 11:30 p.m. on April 6, 2023. However, no further checks of the resident were recorded overnight. . A facility document (undated) titled "steps to follow when a resident falls" details a list of things to do when a resident falls. The document indicated, "Do not get the resident off the ground before the nurse gives the "okay"". The steps detail to call the nurse and "follow nurse instructions for next steps". Step six is to "assist the resident off the floor when instructed by the nurse". The final step is to, "chart in the progress note that the resident had a fall". R2 R2's service plan March 1, 2021, indicated the resident required assistance with dressing, bathing, grooming, meals, medications, laundry, and housekeeping. Staff were directed to complete safety checks every two hours. R2's most recent assessment dated April 12, 2023, indicated the resident was confused and had impaired balance when standing and walking. A facility document dated April 15, 2023, titled, "Investigation for [R2] incident on April 14-15,	02310		

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02310	Continued From page 7 2023, indicated staff were completing safety checks around 1:00 a.m. on April 15, 2023, and R2 was not in her room. Staff began to search and found R2 on her back lying on the ground in the courtyard. R2's lower half of her body was on concrete and R2's head was on the landscape rock. 911 was contacted and R2 was transported to the hospital for evaluation. The document indicated the facility camera footage from the evening of April 14, 2023, was reviewed and R2 was observed going out into the courtyard around 6:48 p.m. R2's service record dated April 14, 2023, indicated ULP-B documented completing safety checks for R2 at 7:00 p.m. and 9:00 p.m. ULP-B documented the 7:00 p.m. safety check occurred at 3:35 p.m. and the 9:00 p.m. safety check occurred at 7:24 p.m. ULP-B charted R2 was assisted with night-time cares and toileted prior to the end of ULP-B's shift at 11:00 p.m. ULP-B documented, "The resident ate 98% of her dinner and she went into her room to sleep." The next shift started at 11:00 p.m. and ULP-C charted the 11:00 p.m. safety check was "not done". During interview on May 3, 2023, at 3:35 p.m., ULP-B stated he locked the courtyard doors at 8:00 p.m., however, he did not go out into the courtyard to ensure all of the residents were in the building. ULP-B stated the last time he saw R2 on April 14, 2023, was approximately 6:50 p.m. ULP-B stated he went to R2's room but her door was locked so he thought R2 was in her room. ULP-B stated R2's evening cares and safety checks were not completed the evening of April 14, 2023. R2's hospital notes dated April 15, 2023, indicated R2 was treated in the Emergency room	02310		

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02310	Continued From page 8 for a urinary tract infection. R2 was prescribed oral antibiotics and sent back to the facility on April 15, 2023. During an interview on April 26, 2023, at 11:31 a.m., administrator (A)-A stated staff were instructed to walk the premises of the courtyard prior to locking the doors around 8:00 p.m. No further information was provided. Time period for correction: Two (2) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two resident(s) (R1 and R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and individual(s) were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	