Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL322768969M
Compliance #: HL322766498C

Date Concluded: April 23, 2024

Name, Address, and County of Licensee Investigated:
Prelude Homes & Services
4650 White Bear Parkway #306
White Bear Lake, Mn. 55110
Ramsey County

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

Evaluator's Name: Michele Larson, RN
Kathy Barnhardt, RN
Special Investigators

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) emotionally abused and neglected the resident when the AP left the resident unattended and unassisted during cares. In addition, the AP physically abused the resident when she grabbed the resident's arm while trying to force the resident to stand up.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined emotional, physical abuse, and neglect were substantiated. The AP was responsible for the maltreatment. The resident was unable to stand without staff assistance, yet recorded camera footage showed the AP remove the resident's wheelchair and aggressively force the resident to stand and hold unto a bathroom grab bar without staff assistance. The AP ignored the resident as she cried stating she was unable to stand and needed to sit down. Additional recorded camera footage showed the AP roughly grab the resident's arm while trying to force the resident to stand up against the resident's wishes.

The investigators conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The resident's family member and case manager were interviewed. The investigation included review of the resident's facility, hospital, hospice, and death record, the facility's internal investigation, incident reports, staff schedules, the AP's personnel file, related facility policy and procedures, the law enforcement report, and recorded camera footage from the resident's room. The investigators observed resident cares during their onsite investigation.

The resident resided in an assisted living with memory care for five months. The resident's diagnoses included dementia without behavioral disturbance, fractures of the thigh, (femur) bone, and ribs. The resident was non-ambulatory, had decreased muscular coordination, difficulty standing, walking, and required frequent observation. The resident's hospice assessment indicated the resident fatigued easily and was accepting and calm. The resident was at increased risk for falls due to her balance problem with standing and walking, and susceptible to abuse by others.

The resident's record indicated one day an unidentified staff person notified the resident's family member about concerns with the resident's care and directed the family member to view the resident's recorded camera footage for that day. Upon review of the recorded camera footage the family member filed a police report and submitted multiple video clips from the resident's apartment.

Review of the police report's recorded audio and camera footage indicated at 6:24 a.m., the AP, with the resident in the resident's bathroom repeatedly, with a raised voice, yelled at the resident and aggressively demanded the resident stand and hold the grab bar even though the resident said she was too weak to stand. Twenty-two minutes later, the AP again with a raised voice yelled at the resident to stand-up and hold the grab bar. After the resident stood, the AP removed the resident's wheelchair from the resident, leaving the resident unable to sit down. On the recorded camera clips, the AP left the resident standing alone while the AP walked in and out of the bathroom a few times for an undetermined amount of time. The resident was heard stating, "help me, help me. I can't really stand up. I gotta sit down, can I sit down?" Moments later the AP entered the bathroom holding a brief and stated, "the thing is right, you can walk."

In subsequent recorded camera clips, the AP grabbed the resident's cell phone from the resident and tossed the phone across the resident's bed taunting the resident. When the resident asked for her cell phone back, the AP said to the resident, "I don't know what you're talking about." In addition, in the recorded camera clips with the AP within inches of the resident's face and with a raised voice, told the resident to stand-up. At one point, the AP roughly grabbed the resident's right arm in an attempt to forcibly pull the resident to a standing position. The resident responded by screaming and quickly flopped down in her wheelchair, crying, and covering her face with her hands while the AP laughed at her. At that time, the recorded camera clip shows the resident with her pants pulled down to her knees. The AP

laughed at the resident, and said to the resident, “You know what? You can sit like that. I’m walking out of here, uh uh, I’m walking out of here.” The AP left the resident’s apartment.

During an interview, unlicensed personnel stated she took care of the resident daily and stated the resident was non-weight-bearing at the time of the incident with the AP.

During an interview, another unlicensed personnel stated the resident was alert, oriented, and easy going. The unlicensed personnel stated the resident was a one-person assist for “a while,” but then a two-person assist after she was admitted to hospice.

During an interview, the resident’s hospice case manager stated in the beginning the resident was a heavy assist of one and required someone to help her stand and sit, stating the resident was very weak. The case manager stated after the incident the resident told her, “Staff here were very bad.” The case manager stated she expedited the resident’s emergency relocation to another facility, stating the resident feared for her safety. The case manager stated the resident felt reassured when she heard she would be immediately moving out of the facility.

During an interview, the facility nurse stated the resident needed someone close when the resident stood and stated it was unsafe for the AP to leave the resident standing in the bathroom alone. The facility nurse stated, “that’s not something I recommend or agree to, to leave her (resident) hanging onto the grab bar.”

During an interview, the AP stated she had a “serious mental problem,” following a head injury a few years ago. Earlier in the interview, the AP stated she thought the resident should have been a two-person transfer but later the AP changed her story and stated she knew the resident could walk and at times transfer herself from her bed to her wheelchair. The AP denied abusing and neglecting the resident, stating if she did, the AP could not recall because of her memory issues.

The resident’s family member stated the day of the incident a staff person texted her to check the resident’s recorded camera footage for that day. The family member stated after reviewing the camera footage, the family member immediately went to the facility to show the footage to facility leadership. The family member stated the resident required staff assistance with standing, mobility, and transfers, and was unable to stand up alone. The family member stated the resident told her the AP made her feel like an animal.

In conclusion, the Minnesota Department of Health determined abuse and neglect were 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.

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. The resident is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

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 03/20/2024

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****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER 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: #HL322766498C/HL322768969M On March 20, 2024, 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 27 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL322766498C/HL322768969M, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. 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. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 1 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 one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was 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 required for tag 2360. Please refer to the public maltreatment report for details.	