Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326081643M
Compliance #: HL326083182C

Date Concluded: January 10, 2023

Name, Address, and County of Licensee Investigated:
Lodge of Eden Prairie (Pioneer Estates)
8751 Preserve Blvd
Eden Prairie, MN 55344
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Not Substantiated

Nature of Visit:
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):
#1 The facility neglected a resident when the facility incorrectly administered morphine to the resident and caused an allergic reaction.

#2 The facility neglected the resident when the facility did not provide cares such as showers for several weeks causing skin breakdown or only offered the resident leftovers to eat.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the facility did administer morphine to the resident, the facility did so according to physician orders and there was no known history of allergy nor documentation of an allergic reaction. The investigation did not identify evidence the resident's experienced skin breakdown due to

missed showers nor was there evidence of an extended period of no showers. The investigation did not identify evidence of problems with meal service at the facility.

The investigator conducted interviews with facility staff members, including individuals from administration, nursing, and unlicensed care givers. The investigator contacted the regional ombudsman for an interview. The investigation included a review of the resident's medical records from the facility, the resident's primary caregiver, and pain clinic. The investigation investigator reviewed the resident's services provided documentation including shower schedules. The investigation included an onsite visit.

The resident resided in an assisted living facility. The resident's diagnoses included spinal cord injury, quadriplegia, and chronic pain. The resident's service plan included services with all personal cares, medications, meals, and housekeeping. The resident's medical record indicated he received cares from a pain clinic to address his chronic pain.

A review of the resident's medical record indicated there were medication listed as allergies however morphine was not included in this list.

The resident's medical record indicated his physician prescribed morphine, which the facility administered. The same documents indicated the resident did not tolerate the morphine, so his pain medication was changed. A review of the medical record did not identify an occurrence of an allergic reaction to morphine although it does indicate the resident did not tolerate morphine. The same documents indicated the resident's physician prescribed several pain medications, dosages, and schedules over time in an attempt to find an effective treatment.

The resident's services-received documentation indicated the resident received at least one weekly shower. The same document indicated multiple occasions the resident received two showers a week.

A review of the resident's assessments covering approximately six months indicated the resident did not have skin issues or breakdown.

During an unannounced onsite visit, the investigator observed residents from two homes operated by the facility. The investigator observed the residents were clean and wearing appropriate clothing. The investigation included an observation of a meal which included a breakfast bar with muffins, tea, and coffee available. The observations included menus placed on table listing items available for request by the residents. The investigator observed interactions between staff members and the residents but did not identify any concerns.

During an interview, the resident stated he had been at the facility for over three years and his showers were missed frequently. He said he went many weeks without a shower sometime last year. When asked when he received his last shower, he confirmed it was the previous Monday and his schedule called for showers both Mondays and Fridays. He also stated the facility would

not give him the medication until the physician sent over the prescription. The resident stated he had a bad reaction from morphine and no longer takes this medication.

During an interview, the operations manager stated the resident had morphine prescribed at one time about a year ago but none currently. She stated the physicians tried different kinds of medications to address the resident's pain. However, the resident report of pain did not improve so the physician referred him to a pain clinic. The operations manager stated the resident has raised concerns about showering and she had worked to ensure he receives them. She stated she there have been occasions she has witnessed the caregivers give the resident a shower but later he denies the caregivers did. The operations manager also stated there are times the resident refuses showers, but the resident has no current skin breakdown or rashes. The operations manager stated the resident is usually one of the first persons served meals due to the location of his room near the kitchen.

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: Yes
Family/Responsible Party interviewed: No
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action required.

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
	32608	A. BUILDING: _____ B. WING _____	C 12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER ESTATES	8761 PRESERVE BOULEVARD EDEN PRAIRIE, MN 55344

(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 Initial comments On December 27, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL326081643M/HL326083182C. No correction orders are issued.	0 000		