Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL331493822M
Compliance #: HL331494342C

Date Concluded: August 23, 2024

Name, Address, and County of Licensee Investigated:
Meadow Place Assisted Living
220 CentraCare Drive 11
Long Prairie, MN 56347
Todd County

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

Evaluator's Name:
Katherine Barnhardt 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 facility neglected resident #1 and resident #2 when the facility failed to provide supervision and resident #2 was found in resident #1's apartment in bed and on top of resident #1.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. At the time of the incident, facility staff were following resident #2's care plan for supervision. Despite the interventions, resident #2 was discovered leaving resident #1's apartment and staff increased resident #2's supervision until alternate placement was arranged for resident #2.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and a family member. The investigator contacted law enforcement. The investigation included review of resident #1 and resident #2's records, pharmacy records, facility internal investigation, facility incident reports, staff schedules, related

facility policy and procedures. Also, the investigator observed interactions and cares between residents and staff.

Resident #1 resided in an assisted living memory care unit. The resident's diagnosis included dementia. The resident's service plan included assistance with behavior management, meals, and safety checks. The resident was independent with most activities of daily living, ambulated with a cane, would request staff assistance when needed and had moderately impaired decision-making skills.

A review of resident #1's record indicated the resident preferred time alone in her room, would often keep the door locked and effectively used a call pendant. The record indicated resident #1 would exit her room for meals and intermittent activities, however, did not trust anyone. Resident #1's record indicated one afternoon when resident #1's door was unlocked resident #2 entered resident #1's room uninvited and a resident-to-resident altercation occurred.

Resident #2 resided in an assisted living memory care unit. The resident's diagnosis included dementia with sexual disinhibition. The resident's service plan included assistance with behavior management, dressing, meals, and safety checks. The resident's assessment indicated resident #2 was independent with mobility, required minimal staff assistance with activities of daily living and was oriented only to self with memory impairment.

A review of resident #2's record indicated resident #2's dementia progressed significantly while a resident at the facility. Resident #2 had escalating sexual inhibitions due to frontal lobe dementia and medication changes were often made by the resident's provider to address behaviors. The medication changes were ineffective, and the medical provider recommended resident #2 be relocated to a specialized facility. Resident #2's record indicated staff moved resident #2 from one room to another for closer staff observation and resident #2 was placed on 15-minute safety checks. Hospice services were started to provide additional support to resident #2 until resident #2 could be relocated to a specialized facility. Resident #2's record indicated a couple months after the facility's initial request for resident #2's emergency relocation was denied, legal actions were implemented and resident #2 was moved to a specialized facility.

The incident report indicated during an afternoon shift change resident #1 was heard yelling for staff assistance. Staff arrived and found resident #2 leaving resident #1's room. The incident report indicated resident #1 stated resident #2 held her down, stated he was going to rape her, and she fought back. Both residents were fully dressed, and resident #1 remained under blankets at the time of the incident. Unlicensed staff remained with resident #1 and resident #2 until licensed staff arrived at the facility. The incident report indicated both memory care residents sustained skin injuries.

An internal investigation report indicated during an afternoon shift change resident #1 was lying in her bed and was heard yelling for staff assistance. Staff immediately arrived and found

resident #2 leaving resident #1's room. Resident #1 and resident #2 sustained skin injuries during the altercation. The internal investigation included a licensed staff interview with resident #1 and resident #2. The investigation interviews indicated resident #1 stated resident #2 tried to crawl into bed with her and she fought back, remaining under her blankets during the incident. Resident #2 had no recollection of the incident. The facility notified families, medical providers, law enforcement, provided staff education, and requested assistance from outside agencies. The facility sought alternative placement for resident #2 to a specialized facility and the facility implemented a plan of action.

During an interview, unlicensed staff stated during an afternoon shift change staff heard resident #1 yelling and resident #2 was observed leaving resident #1's room. Unlicensed staff stated they notified licensed staff immediately. Unlicensed staff stated licensed staff conducted an internal investigation, talked to staff, talked to resident #1 and resident #2 and put resident #2 on 15-minute safety checks. Unlicensed staff logged the checks into a paper logbook. Unlicensed staff stated resident #2 did not have sexual inhibition behaviors when admitted to the memory care unit, however, the behaviors escalated, and staff closely monitored resident #2. The unlicensed staff stated they attempted to engage resident #2 in activities, provided redirection and completed 15-minute safety checks. Unlicensed staff stated resident #1 kept her door locked for the most part and staff would knock to be let in.

A review of resident #2's safety check log sheets following the altercation between resident #1 and resident #2, staff verified the action and whereabouts of resident #2 every 15 minutes throughout all shifts.

During an interview licensed staff stated when resident #2 began exhibiting an increase in dementia behaviors, the facility implemented numerous interventions, kept the families informed, updated the provider sometimes as often as three times weekly and had actively pursued placement for resident #2 to an all-male facility as recommended by resident #2's provider. Licensed staff stated resident #2's provider placed orders for a geriatric psychiatric stay to review and establish an effective medication regime, as the many medication changes that had been made to address resident #2's behavior were ineffective. The psychiatric facility was unable to accommodate resident #2 at the time of request. The licensed staff stated hospice was initiated as support for resident #2 and provide aide to the facility in seeking alternative placement. The licensed staff stated resident #2 remained on 15-minute safety checks while alternative placement was pursued. Licensed staff stated when an all-male facility accepted resident #2, an emergency relocation of resident #2 ensued.

During an interview with a family member, the family member stated resident #1had resided at the facility for about four years and stated the facility "has been great". The family member stated resident #1 often kept her door locked and didn't like anyone entering her room. The family member had no concerns about the care provided to resident #1 by facility staff.

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.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility reviewed incidents, implemented interventions, provided staff education, requested assistance from outside agencies and pursued relocation services.

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
	33149	A. BUILDING: _____ B. WING _____	C 08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW PLACE ASSISTED LIVING	220 CENTRACARE DRIVE LONG PRAIRIE, MN 56347

(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 13, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL331493822M/#HL331494342C. No correction orders are issued.	0 000	Assisted Living Provider 144G. 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 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 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 evaluators' 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 SUBDIVISION 1-3.	