DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL34601001M
Compliance #: HL34601002C

Date Concluded: October 18, 2022

Name, Address, and County of Licensee Investigated: Prelude Homes and Services
10018 Raleigh Road
Woodbury, MN 55125
Washington County

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

Evaluator's Name: Stacia Hansen, RN
Special Investigator

Finding: Inconclusive

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):
The alleged perpetrator (AP) abused a resident when two bruises and a scrape were found on the resident after the AP provided care during an overnight shift.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The investigation found insufficient evidence to determine the AP responsible for causing the injuries on the resident.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigation included review of the resident's records, policies and procedures, incident reports and the AP's personnel file. Also, the investigator toured the facility and observed resident/staff interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and depression. The resident's service plan included assistance with bathing,

dressing, grooming, toileting, and medication administration. The resident's assessment indicated he was able to walk with an assistive device (walker) and 1 person stand by assist. The resident's indicated the resident has chronic left rib cage pain.

The facility's investigation notes indicated an administrative staff member, the nurse and family members had a meeting. At the meeting family members voiced concerns about the resident's report of someone throwing a pillow at him during the night. The same document indicated there were no signs of physical injury at the time of the meeting. The investigation notes indicated the administrative staff member talked with the AP who stated the resident was a little resistive to toileting during the night shift. In addition, the facility's investigation notes indicated eight days later the administrative staff member received a phone call from a family member regarding the resident's report to her of someone hitting him overnight.

The resident notes indicated one morning the nurse spoke with the resident's spouse who reported the resident had right side pain, so the nurse performed a physical assessment on the resident and a photograph was taken of the injuries. The resident notes indicated a family member reported the resident told her "a guy was rough with him last night". The resident note at approximately 11 a.m., indicated the resident complained of pain on his right side and she found two bruises and a scratch on his right upper quadrant

A review of the facility scheduled indicated the AP worked the previous night shift, which ended at 7 a.m.

During an interview, the administrative staff member stated the AP denied he injured the resident.

During an interview, the nurse stated she completed a physical assessment on the resident after the incident was reported. The nurse stated she found bruising and a scratch on the resident's upper right side which was also noted in a photograph.

During an interview, the family member stated the resident reported to her there was a male caregiver who worked the overnight shift, and he would hit the resident. The family member stated the resident has dementia, but he knows when he is being treated poorly. The family stated a facility staff member told her residents can get bruises from bedrails.

During an interview, another family member stated the resident reported to her there was a male staff member who was mean to him at night and punched him in the side.

The investigation identified no other witnesses to the alleged events.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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

Vulnerable Adult interviewed: No, he cannot recall incident due to dementia
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No, attempts to contact the AP unsuccessful including subpoena

Action taken by facility:
The facility investigated the family's concern. The facility no longer employs the AP.

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
	34601	A. BUILDING: _____ B. WING _____	C 09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRELUDE HOMES AND SERVICES	10018 RALEIGH ROAD WOODBURY, MN 55129

(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 ******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: #HL34601002C/#HL34601001M and #HL34601004C/#HL34601003M On September 7, 2022, 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 23 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL34601004C/#HL34601003M, tag identification 0740.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
0 740 SS=D	144G.43 Subd. 4 Transfer of resident records With the resident's knowledge and consent, if a	0 740		

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0 740	Continued From page 1 resident is relocated to another facility or to a nursing home, or if care is transferred to another service provider, the facility must timely convey to the new facility, nursing home, or provider: (1) the resident's full name, date of birth, and insurance information; (2) the name, telephone number, and address of the resident's designated representatives and legal representatives, if any; (3) the resident's current documented diagnoses that are relevant to the services being provided; (4) the resident's known allergies that are relevant to the services being provided; (5) the name and telephone number of the resident's physician, if known, and the current physician orders that are relevant to the services being provided; (6) all medication administration records that are relevant to the services being provided; (7) the most recent resident assessment, if relevant to the services being provided; and (8) copies of health care directives, "do not resuscitate" orders, and any guardianship orders or powers of attorney. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide necessary medical information during a transfer to the hospital for one of two (R2) residents, who was sent to the hospital via ambulance. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	0 740		

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0 740	Continued From page 2 only occasionally). The findings include: R2's diagnoses included neurocognitive disorder, depression, diabetes, and hypertension. R2's service plan dated November 17, 2021, indicated R2 received services including assistance with bathing, dressing, grooming, and medication administration. R2's nursing notes dated March 18, 2022, at 4:32 a.m., indicated the on call nurse received a call from a staff member about a resident laying against the door on the floor in her room. The resident notes indicated the staff member was not able to gain entrance to the resident's room so 911 was called and paramedics transported the resident to the hospital. During an interview on September 14, 2022, at 3:01 p.m., registered nurse (RN)-B stated the facility did not send any records with the resident to the emergency department. During an interview on September 16, 2022, at 10:31 a.m., the licensed assisted living director (LALD)-C stated the resident's records should have been faxed to the hospital. The licensee's policy titled Emergency/911, dated August 1, 2021, indicated following a 911 call, staff will wait for the 911 responder to arrive and have resident information sheet available for medical responder. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 740		