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 #: HL34601003M
Compliance #: HL34601004C

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: 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):
The facility neglected a resident when she fell and was found hypothermic.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility was not responsible for the maltreatment. While it is true the resident fell in her room, while at the facility, the resident sustained no injuries, and the medical record did not indicate she experienced hypothermia. A facility staff member failed to be prepared for the arrival of emergency medical services (EMS) when she could not provide any of the resident's personal or medical information to them.

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 hospital records. 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 neurocognitive disorder, diabetes, depression, and hypertension. The resident's service plan included assistance with bathing, dressing, grooming, oral cares, and medication administration. The resident was independent with walking but needed help with transfers (one person assist).

The resident notes 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 and 911 was called. Initially, EMS could not gain entry via the door but entered via a window. The same document indicated the resident was lying on the floor, uncovered and cold while complaining of neck pain and had an abrasion on her forehead, so paramedics placed her in a neck collar and transported her to the hospital.

The resident's hospital records indicated the emergency department provider believed the resident had a mechanical fall and there was no specific cause for the fall other than weakness. The hospital records indicated the resident had multiple imaging studies, no injuries were found, and did not indicate the resident had hypothermia. The same documents indicated the resident was not able to be discharged back to her memory care unit due to a lack of nursing care available at the assisted living facility. The resident had an unsteady gait and was kept for observation but transferred to another hospital as there were no beds at the initial hospital, she was sent to according to the hospital records. The resident's hospital stay was uneventful, and she was able to participate in physical and occupational therapy prior to returning to memory care.

During an interview, the administrative staff member stated the resident had a queen size bed which was too big for her room so they assumed the resident rolled out of bed and this was the reason her body must have blocked the door.

During an interview, the nurse stated when EMS arrived at the facility the staff member could not give any details to EMS, such as the resident's name or medical history. The nurse stated the staff member did not send a copy of the resident's medical records with the resident to the emergency department.

During an interview, the family member stated he received a voicemail message from the on-call nurse to notify him of the resident's fall and transfer to the hospital.

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, deceased (not related to this incident)
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility sent the resident to the hospital to be evaluated after she was found after the fall.

Action taken by the Minnesota Department of Health:
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.

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		

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
0 740	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		

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
0 740	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		