Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL346012581M
Compliance # HL346011755C

Date Concluded: August 5, 2024

Name, Address, and County of Licensee Investigated:
Prelude Homes and Services
10020 Raleigh Road
Woodbury, MN 55129
Washington County

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

Evaluator's Name: James Larson, RN
Special Investigator

Finding: Inconclusive

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 the resident when staff failed to report a change in condition when the resident was found unresponsive.

The alleged perpetrator (AP)/facility staff member abused the resident when the AP grabbed the resident's ankles to put him back into bed.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. It is unable to be determined if the actions or inactions of facility staff contributed to the resident's change in condition. The resident was treated at a local hospital and returned to his baseline health condition.

The Minnesota Department of Health determined abuse was inconclusive. Although the AP transferred the resident inappropriately, the error in procedure was an isolated incident and the resident returned to their baseline condition.

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigator also contacted the resident's family. The investigation included review of resident records, a death record, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, training materials, and related policies and procedures. Also, the investigator toured the facility and observed staff to resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included amyotrophic lateral sclerosis (ALS), dementia, and a compression fracture of the spine. The resident's service plan included assistance with activities of daily living, transfer and repositioning assistance, medications, meals, and housekeeping. The resident was able to independently get out of bed but required assistance to sit up, and supervision to ensure safety with transfers and ambulation.

Facility documentation indicated that one morning, staff were unable to wake the resident to take his morning medications. Later that morning, a family member arrived at the facility and found the resident unresponsive. Staff monitored the resident's condition and upon arrival of another family member three hours later, the resident was transferred to the hospital for further evaluation. The resident was evaluated and returned to the facility later that day with a recommendation for admission to hospice care.

During an interview, facility administration stated that the resident was initially found to be lethargic; staff followed procedures and notified the on-call nurse when there was an observed change in condition.

A further review of complaint documents indicated that weeks later, an unlicensed staff member/alleged perpetrator (AP) was seen on surveillance video entering the resident's room. The resident had gotten himself out of bed and onto the floor. He was kneeling on the side of his bed with his elbows on the mattress supporting his upper body weight. The AP put on gloves and positioned himself behind the resident. The AP then grabbed each of the resident's ankles and with an upward lifting motion, pulled the resident up by his legs while rotating the resident's body off the floor and onto the bed. The resident was now on the lower half of the bed positioned on his right side. The AP proceeded to pull on the resident's right arm and attempted to drag the resident over onto his back and further up on the mattress.

An internal investigation into the incident included an assessment of the resident and suspension of the AP. The resident had no evidence of injury and the AP was retrained on proper transfer techniques.

During an interview, administration stated when they were presented video of the AP's interaction with the resident, the AP was immediately suspended, and an internal investigation was initiated. The AP admitted that he did not properly assist the resident off the ground at the time of the incident.

During an interview, the AP recalled that when he entered the resident's room, he found the resident kneeling next to his bed. The AP asked the resident what he was doing, and the resident said he was praying. The AP stated that his intention was to get the resident back into bed and that he assisted the resident back to bed by lifting him gently by his legs. The AP confirmed that he was not able to return to work until after undergoing additional training and skills testing by a facility nurse.

During an interview with the resident's family member, she stated when she arrived at the facility one morning, she found the resident unresponsive. This change in condition was not typical, and when she asked facility staff about the change in condition, she was told that they noticed this earlier that morning prior to her arrival. Facility staff monitored the resident until additional family members arrived hours later and it was then determined that the resident should be taken to a local hospital for further evaluation. While in the hospital, the resident remained unconscious and was released back to the facility with a referral to hospice care related to his ALS diagnosis. The family member reported they had previous concerns with the care provided at the facility and discussed their concerns at the time with facility staff. The family member felt that the facility addressed the concerns appropriately and had no further concerns with the care provided by the facility.

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

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.

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.

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. Deceased
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility retrained the AP and conducted additional competency testing prior to the AP returning to work. The facility also completed a focused review of the resident's care plan, as well as review of the facility policies and procedures pertaining to falls, repositioning, transfers, and assistance with ambulation.

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.

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

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 05/31/2024

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 On May 31, 2024, the Minnesota Department of Health conducted a complaint investigation #HL346011755C #HL346012581M. 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.	