Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL355613061M
Compliance #: HL355612990C

Date Concluded: June 20, 2024

Name, Address, and County of Licensee Investigated:
Prairie Bluffs Senior Living
10300 Hennepin Town Rd
Eden Prairie, MN 55347
Hennepin County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 members did not administer the resident's atenolol medication (an antihypertensive) for intracranial hemorrhage scheduled at night for multiple consecutive days but still documented it as given.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility medication passers did not administer half tablet of atenolol 25 milligram (mg) for intracranial hemorrhage scheduled in the evening for multiple days. The missed medication was necessary to reduce the resident's risk of intracranial bleed, which was identified when the resident was hospitalized the following day.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records,

internal investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living facility. The resident's service plan included assistance of one person with gait belt and a walker for mobility. The same document indicated the facility provided medication administration services. The resident's assessment indicated he was mildly disoriented to person, place, and time.

One day the resident was admitted to the hospital and diagnosed with an intracranial hemorrhage and a concern arose that the facility had not administered his medications as ordered prior to this hospitalization.

The most recent assessment completed approximately one week prior to this hospitalization indicated the resident's diagnoses included high blood pressure, cerebral amyloid angiopathy, and a history of nontraumatic intracerebral hemorrhage (brain bleed). The same document indicated the resident's blood pressure was 154/89.

The electronic medication administration record (EMAR) indicated the resident was to receive a half tablet of atenolol 25 mg scheduled twice a day: half tablet in the morning and half tablet at night. The medical reason listed for atenolol was listed as intracranial hemorrhage. Aside from an over-the-counter sleep aid, the resident had no other scheduled medications.

During an interview, a family member stated she noticed the resident's blood pressure was high over a period of a few days and notified the nurse the day prior to the resident's hospitalization. The family member stated the nurse came to the unit, pulled out the medication planner (pill box), and told the family member that he had missed his evening medications for four days. The family stated she noticed the planner had slots for both morning and evening doses. The family member stated the nurse expressed surprise because there no medications at night for the whole week, even though there should have been at least two days left before it needed to be refilled. The family member stated the nurse was apologetic.

During an interview, a nurse stated the resident was scheduled to take atenolol twice a day. The nurse stated the family notified her that the resident's blood pressure had been high, and said she thought his evening atenolol was missed a couple of times. She stated she inquired and learned the resident was not given his medication because he was sleeping when medication passers came to give it and they did not want to wake him up. However, the medication passers charted the medication as given even though it was not given and provided the names of the medication passers involved.

A review of the EMAR indicated the resident's atenolol was administered each evening although the statements from the family member and the nurse called this into question.

In an effort to determine if the medical provider was informed of the potential medication error, the investigation included a request for documentation regarding follow-up. Email correspondence with a manager indicated no medication had been missed so no incident report or physician notification was needed.

The same day as the discussion between the nurse and the family member, the occupational therapist notes indicated the resident had more difficulty maintaining midline posture, with an increased lean to his right side. It also indicated that the right upper extremity was less involved, hanging down on the right side of his wheelchair, and exhibited less grip when holding the dowel and parallel bar. The resident also had limited verbalization and engagement during the occupational therapy session. That same day the resident's medical record indicated an unlicensed staff member told the occupational therapist that the resident needed help to eat breakfast that day, which was not typical.

The day after the discussion between the nurse and the family member, the progress notes indicated the family member took the resident to a medical appointment and from there the resident admitted to the hospital.

The hospital records indicated the resident was diagnosed with an acute left-sided intracranial hemorrhage. The same documents indicated the resident had a history of underlying cerebral amyloid angiopathy and found to have a new intraparenchymal hemorrhage (a bleed that occurs within the brain).

The National Library of Medicine indicated cerebral amyloid angiopathy along with hypertension as a common cause of intracranial hemorrhage in the elderly.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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. The resident was deceased.

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

Action taken by facility:
The facility posted a sign reminding medication passers to give the resident his medications.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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
Hennepin County Attorney
Eden Prairie Attorney
Eden Prairie Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35561	A. BUILDING: _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE BLUFFS SENIOR LIVING	10300 HENNEPIN TOWN ROAD EDEN PRAIRIE, MN 55347

(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 23, 2024, the Minnesota Department of Health initiated an investigation of complaint HL355612339C, and HL355613061M/HL355612990C. No correction orders are issued for HL355612339C. For HL355613061M/HL355612990C, the following correction order is issued, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	