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 #: HL355613761M
Compliance #: HL355614207C

Date Concluded: August 14, 2024

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

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

Evaluator's Name:
Katie Germann, RN, Special Investigator

Finding: Substantiated, individual 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 alleged perpetrator (AP) abused a resident when the AP got into a physical altercation with the resident causing the resident to fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The resident hit the AP and the AP grabbed the resident's arm and twisted it. The AP continued grabbing and twisting the residents arms, and when the AP let go of the resident, the resident fell backwards onto the floor.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, camera footage of the incident, facility policies and procedures, and employee records and training.

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The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's dementia with behavioral disturbance. The resident's service plan included assistance with bathing, dressing, grooming, meals, medications, housekeeping, and laundry. The resident's assessment indicated the resident had a history of physical aggression with staff and other residents.

A facility investigation of the incident indicated the facility nurse was notified the next morning of the incident and reviewed camera footage. The investigation indicated the recording of the incident showed the AP assisting a different resident when the resident hit the AP on the back. The AP turned and grabbed the resident by her wrist and twisted it. The other resident fell. The AP then let go of the resident and attempted to get the other resident up off the floor. The resident hit the AP and held on to the other resident's shoulder. The AP attempted to pull the resident off the floor and the resident hit the AP in the face. The AP then grabbed the resident aggressively by the hands and pushed the resident back with force. The AP and the resident struggled, and the AP let go of the resident, who fell back onto the floor.

Review of camera footage of the incident showed the AP walk into the facility day room with another resident, holding the other resident by her hand and pulling her. The AP was attempting to assist the other resident to sit on the couch when the resident came in the room behind the AP pushing a third resident in a wheelchair. The resident hit the AP in the back and the AP turned around and grabbed the resident's hand and twisted her arm. The resident did not let go, and the AP was still holding on to the other resident while being held by the resident, and the other resident fell onto the floor. The AP attempted to assist the other resident off the floor by pulling on her right arm, while the resident continued to hit the AP and grab the other resident on her shoulder. The other resident got up off the floor and sat on the couch. The AP grabbed the resident by her right arm and twisted, then the AP grabbed the resident's wrists and forced/ pushed the resident several feet, while the resident struggled to get free. After the AP pulled the resident by her wrists several feet across the floor, the AP suddenly let go of the resident's wrists causing the resident to fall on the floor.

During an interview, the facility nurse stated she was notified of the incident the morning after it occurred. The facility nurse stated she reviewed the camera footage and saw the AP's actions. The nurse stated she felt the AP's actions caused two residents to fall and the AP was too aggressive with the residents.

During interview, unlicensed personnel stated she worked with the AP on the evening the incident occurred, however, she did not witness the incident. The staff stated the AP called her after the resident was on the floor and told her the resident grabbed her and when the AP turned around the resident fell.

During interview, the AP stated the resident had a history of kicking, hitting, spiting, and scratching. The AP stated during the incident she was trying to deescalate the situation and she was unable to walk away because the resident would have hit somebody else.

In conclusion, the Minnesota Department of Health determined abuse 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.

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, due to cognition
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility filed a report with the Minnesota Adult Abuse Reporting Center. The AP no longer works for the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to

the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

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

Minnesota Department of Health

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 07/02/2024

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 ******ATTENTION****** ASSISTED LIVING PROVIDER 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: #HL355614207C/#HL355613761M On July 2, 2024, 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 85 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL355614207C/#HL355613761M, 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.	02360		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Minnesota Department of Health

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.	02360		