

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL355616724M
Compliance #: HL355612631C

Date Concluded: October 11, 2023

Name, Address, and County of Licensee

Investigated:

Prairie Bluffs Senior Living
10300 Hennepin Town Road
Eden Prairie, MN 55347
Hennepin

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of the 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 she forcefully pulled the resident down the hallway.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP forcefully pulled the resident down the hallway. The abuse was witnessed by a facility direct care member and captured on video surveillance.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of resident's records, the APs personnel record, facility's policies and procedures, incident reports and reviewed pertinent video surveillance. The video did not include audio. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance of one person with bathing, dressing, grooming, and medication administration. The service plan also indicated to redirect the resident with activities if the resident wandered. The resident's assessment indicated the resident transferred and ambulated independently, wandered at night, and was identified as an elopement risk.

One weekend video footage from surveillance showed the AP initially assisting a resident by holding the resident's right arm with both of her arms as they walked towards the hallway. However, when they reached the corner to enter the hallway the resident stopped, grasped the handrail with his left hand and resisted going further. The AP responded by pulling and tugging at the resident by the right arm and right sleeve until his grip gave way on the handrail. The two moved a few more feet down the hallway at a time as the resident continued to cling to the handrail and she continued to pull him forcefully.

At about the one-minute mark of the video footage a third person, who witnessed the event, approached the resident on his left side from behind. However, he pushed her away and she backed off. The AP once again used force to pull the resident away from the wall just as the resident let go of the handrail with his left hand. As a result, the resident was swung to the opposite side of the hallway. The AP then directed the resident toward the center of the hallway to continue the walk

At approximately the one-minute and fifteen second mark of the video footage the resident again reached out to the handrail with his left hand. While the AP continued to pull him down the hallway, he lowered himself to the floor.

At approximately the one-minute and thirty second mark the AP then walked away from the resident down the hallway. However, when she tried to walk back up the hallway past him on the floor, he stuck his leg out towards her and she tripped. After a brief scuffle with the resident on the floor in which she held his hands and arms down towards his body, she got up and walked away.

By the two-minute and thirty second mark of the video footage, the AP had returned and stood near the resident as he sat on the floor in the hallway. The AP waited for about five minutes until the resident stood up and they continued to walk calmly down the hallway as he held onto the handrail with his right hand.

During an interview, the AP stated she saw the resident standing between the exit door and another resident's door at the beginning of her shift. She attempted to redirect him to the communal living area, but he appeared confused and reluctant to move. She stated she was not forcing him to move but rather he was leaning against the wall, and she was trying to assist him.

She stated the resident's behavior became increasingly aggressive, and he attempted to hurt both her and the witness. The AP stated the resident did not fall; rather, he ended up on the floor because she lowered him down when he became unsteady. While dealing with the situation, she sought assistance from the witness but did not call from another direct caregiver. The AP stated she observed the resident had a minor cut from the floor, so she wrote an incident report and left it in the manager's office.

During an interview, the witness confirmed she was present when the AP tried to move the resident down the hallway. She stated the resident was attempting to do something, and the AP forcibly pulled him down the hallway. She asked the AP to leave the resident alone due to his behavior, but the AP did not heed her suggestion. The witness said she was still in training and hesitated to get directly involved. She suggested the AP call for assistance from other staff members, but the AP did not.

During an interview, a licensed practical nurse stated she worked that weekend and one of the caregivers informed her of the resident's bruise. She went to look at it, cleaned the area, and applied a band-aid. Additionally, she documented the bruise in the progress notes and notified both the registered nurse and the triage nurse.

During an interview, the registered nurse stated she did not work on the weekend but upon arriving at work, she discovered the incident report the AP had left in her office. Subsequently, she assessed the resident's bruise and reported it to the management team.

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. The resident was deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility completed an internal investigation, reported the incident to the state agency, assessed the resident, and provided re-education or training to AP and the witness.

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 City Attorney

Eden Prairie Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35561	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/18/2023
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NAME OF PROVIDER OR SUPPLIER PRAIRIE BLUFFS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 10300 HENNEPIN TOWN ROAD EDEN PRAIRIE, MN 55347
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(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 September 18, 2023, the Minnesota Department of Health initiated an investigation of complaint HL355612631C/ HL355616724M. The following correction order is issued, tag identification 2360.	0 000		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual alleged perpetrator was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p>	02360	No plan of correction is required for this tag.	

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