Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL355618467M
Compliance #: HL355615689C

Date Concluded: April 1, 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: Not Substantiated

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) neglected the resident when she failed to perform scheduled care, resulting in the resident developing pressure ulcers.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the AP did not provide "check and change" cares as scheduled one time, it was an isolated event. Several days later the facility identified two pressure wounds on his skin, but it was not clear these events were related. The facility provided the resident treatment and the wounds healed.

The investigator conducted interviews with facility staff members, including administrative 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’s diagnoses include lung cancer and type 2 diabetes. The resident’s service plan included assistance with all activities of daily living which included hygiene, dressing, toileting, medications, meals, and housekeeping. The service plan also included two-hour safety checks throughout the day and night.

The facility received a report from a staff member a few days after the incident asserting the AP did not perform a scheduled check and change for the resident. The day after receiving the report, the facility assessed the resident's skin and identified two open areas near the resident's right gluteal fold. The facility notified the resident’s family and medical provider. A wound care consult was arranged, and treatment orders were obtained.

The wound tracking form indicated the resident’s wound resolved in less than 10 days from the time it was identified.

The AP’s employee file indicated the facility provided the AP with re-education regarding check and change cares.

During an interview, the manager stated the AP did not perform a check and change only one time, due to a misunderstanding of staff duties. Upon learning about the incident days later, a nurse did an assessment and noted two open areas. She then consulted a wound specialist, wound care was provided, and the wound healed. She said education and training sessions were provided for the AP, emphasizing that staff were supposed to check and change every two hours. Additionally, she updated hospice, provider, and the family about the incident.

During an interview, the AP stated the resident needed to be changed and repositioned every two hours. At that time there was a lot of confusion regarding repositioning the resident, which led her to not perform the scheduled check and change for him. The AP said the facility followed up with her with re-education.

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, resident no longer at the facility.
Family/Responsible Party interviewed: No, attempts not successful.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility provided the AP with corrective action and re-education along with a supervisory review with the AP.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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
	35561	A. BUILDING: _____ B. WING _____	C 03/06/2024

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 March 6, 2024, the Minnesota Department of Health initiated an investigation of complaint HL355619950M/HL355618156C, HL355619485M/HL355617229C and HL355618467M/HL355615689C . The following correction orders are issued No correction orders are issued for HL355618467M/HL355615689C. For HL355619950M/HL355618156C and HL355619485M/HL355617229C: correction order identification 1950 and 2360 .	0 000	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 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.	
01760 SS=J	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date	01760		

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 03/06/2024

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
01760	Continued From page 1 and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the license failed to ensure and/or double check the newly hired licensed practical nurses after they did medication transcriptions for two of two residents (R1 and R2) reviewed resulting in medications not administered as prescribed. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), 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 only occasionally). The findings include: R1 R1's face sheet indicated R1 admitted to the facility on April 13, 2022, with current diagnoses of hyperlipidemia and hypertension. R1's service plan effective dated September 1, 2023, indicated R1 required assistance medication management three times daily. R1's medication sheet, Losartan 50 milligram (mg) tablet (take one tablet by mouth once daily)	01760		

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 03/06/2024

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
01760	Continued From page 2 and Atorvastatin 20 mg tablet (take one tablet by mouth once daily) were discontinued on August 25, 2023. R1's progress notes dated December 12, 2023, at 6:26 p.m. indicated R1 was sent to the Emergency Room (ER) on the same day. The ER nurse inquired about Losartan and Atorvastatin, which were not listed in the facility's medication list. The progress notes indicated the "facility received an order for both medications, and they have been included in the medication cycle since July 10th, 2023. The current order from the primary care provider indicates that the resident should be taking scheduled Atorvastatin 20mg and Losartan 50mg daily. However, there are no signs of these medications in the medication cart." On March 7, 2024, at 9:58 a.m., licensed practical nurse (LPN)-D stated the management staff called and said she was the one who discontinued the medication. She said if R1 missed the medication for three months, it must have occurred during her training period. She said she did not remember doing it or knowing anything about it. She further stated if the medications were delivered by the pharmacy, it was the responsibility of the registered nurse (RN) and an LPN to cross-reference them with the medical records. On March 6, 2024, at 3:02 p.m., Director of Nursing (DON)-A stated R1 was sent to the hospital for back pain, and it was then discovered that two of R1's medications, atorvastatin, and losartan, were discontinued three months ago by LPN-D without physician's orders. She said LPN-D had worked there for about a month when the order was discontinued. She discussed the	01760		

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 03/06/2024

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
01760	Continued From page 3 matter with LPN-D, who did not remember or know anything about it. LPN-D did not return to work as she had already submitted her notice. On March 6, 2024, at 3:02 p.m., (RN)-B stated LPN-D could have confused and discontinued the medication when the pharmacy continued sending confirmations through the system despite the orders already being in place. Following the incident, she contacted the pharmacy to find a solution to simplify the process and reduce confusion. She said even though the medications were discontinued on their system, The pharmacy's system still had those medication in R1's medical records. Therefore, the pharmacy kept sending the medication over, instead of verifying, the staff destroyed it. (RN)-B said it was the nurse's responsibility to check, and LPN-D failed to do so. She said they did not have any staff training session after this incident. On March 14, 2024, at 4:08 p.m., the pharmacy technician stated according to the records, the pharmacy delivered R1's Losartan and Atorvastatin every thirty days. R2 R2's face sheet indicated R2 admitted to the facility on June 6, 2022, with current diagnoses of atrial fibrillation, and hypertension. R2's service plan effective dated November 6, 2023, indicated R2 required assistance with medication management three times daily. R2's medication sheet indicated the following medications were missed on November 6, 2023, through November 9, 2023:	01760		

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 03/06/2024

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
01760	Continued From page 4 Eliquis 2.5 mg tablet one tablet by mouth twice daily Lasix 20 mg tablet one tablet by mouth once daily Isosorbide mono 30 mg tablet one tablet by mouth once daily Spironolactone 25 mg tablet one tablet by mouth once daily Atorvastatin 10 mg tablet one tablet by mouth every night at bedtime A review of the manufacturers website (https://www.eliquis.bmscustomerconnect.com) indicated do not stop taking Eliquis without talking to the doctor who prescribed it for you. For patients taking Eliquis for atrial fibrillation: stopping Eliquis increases your risk of having a stroke. R2's progress notes dated November 10, 2023, at 5:00 p.m. indicated R2 was assessed due to not receiving some of her medications for a few days. R2's right leg became swollen more than the left leg. R2 said it was sore. R2's progress notes dated November 12, 2023, at 12:03 p.m. indicated R2's speech slurred and could not open her eyes. R2 kept touching her head. R2's daughter was at the facility and advised staff to call 911. R2's hospital records dated November 12, 2023, indicated R2 was diagnosed with an acute cerebrovascular accident (CVA or stroke). The same documents indicated R2's speech was garbled with a sudden onset of aphasia. The records included imaging which indicated a "thrombus" (blood clot) associated with the CVA. On March 13, 2024, at 12:04 p.m., family	01760		

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 03/06/2024

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
01760	Continued From page 5 member (FM)-C stated she visited the resident three days after the resident was discharged from the hospital. She noticed the unlicensed caregivers had only given the resident Tylenol, so she inquired about the resident's other medications. Upon checking the medication cart, the unlicensed caregiver found the other medications present but not listed on R2's electronic medication administration record (EMAR). FM-C expressed concern R2 had missed her medications for three days, and the facility was unaware until her visit. Following a discussion with the management team, they promised to order an ultrasound to check for a blood clot, as the resident's right leg was swollen. However, the ultrasound would not be done until November 13, 2023. On November 12, 2023, the resident experienced slurred speech and had a stroke, prompting transfer to the hospital. FM-C said R2 was in intensive care unit for two days and discharged to transition care unit before she went back to facility. On March 6, 2024, at 4:09 p.m., LPN-E stated R2 was self-administered medications before being admitted to the hospital for a hip surgery. She said she was new at the time and did not realize she had to switch from self-administered to facility administered for the medication passers to see. On March 6, 2024, at 3:20 p.m., DON-A stated R2 was initially in the assisted living side and was transferred to the hospital for a broken hip after a fall. Upon discharge from the hospital, R2 was relocated to the enhanced care unit, which required more care. During her time there, the family observed that she did not receive all her medications and notified them. It was noted that she missed three days of medication.	01760		

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 03/06/2024

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
01760	Continued From page 6 Unfortunately, she returned to the hospital again on November 12, 2023, for slurred speech. On March 6, 2024, at 3:20 p.m., RN-B stated prior to R2's fall, she was self-administering medication. Upon R2's return, LPN-E did not realize the medications already in the system were set for self-administration and added new medications. The missed medications were the ones R2 used to take independently. When LPN-E processed the order, she failed to lift the button orders for the med passers to see. It was brought to RN-B's attention by a family member, and a registered nurse reviewed the situation. RN-B stated LPN-E had been working there for approximately a month when the incident occurred. After the incident, the provider was notified, and an ultrasound was ordered due to R1's red and swollen right leg. Unfortunately, R2 developed slurred speech and was promptly hospitalized before the ultrasound could be conducted. The licensee's Uniform Assessment Tool policy dated August 1, 2021, indicated for each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.	01760		

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 03/06/2024

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
01760	Continued From page 7 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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 two of two residents reviewed (R1, R2) was free from maltreatment. Findings include: Regarding HL355619950M involving R1 and HL355619485M involving R2 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 (POC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

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 03/06/2024

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 March 6, 2024, the Minnesota Department of Health initiated an investigation of complaint HL355619950M/HL355618156C, HL355619485M/HL355617229C and HL355618467M/HL355615689C . The following correction orders are issued No correction orders are issued for HL355618467M/HL355615689C. For HL355619950M/HL355618156C and HL355619485M/HL355617229C: correction order identification 1950 and 2360 .	0 000	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 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.	
01760 SS=J	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date	01760		

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 03/06/2024

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
01760	Continued From page 1 and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the license failed to ensure and/or double check the newly hired licensed practical nurses after they did medication transcriptions for two of two residents (R1 and R2) reviewed resulting in medications not administered as prescribed. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), 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 only occasionally). The findings include: R1 R1's face sheet indicated R1 admitted to the facility on April 13, 2022, with current diagnoses of hyperlipidemia and hypertension. R1's service plan effective dated September 1, 2023, indicated R1 required assistance medication management three times daily. R1's medication sheet, Losartan 50 milligram (mg) tablet (take one tablet by mouth once daily)	01760		

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 03/06/2024

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
01760	Continued From page 2 and Atorvastatin 20 mg tablet (take one tablet by mouth once daily) were discontinued on August 25, 2023. R1's progress notes dated December 12, 2023, at 6:26 p.m. indicated R1 was sent to the Emergency Room (ER) on the same day. The ER nurse inquired about Losartan and Atorvastatin, which were not listed in the facility's medication list. The progress notes indicated the "facility received an order for both medications, and they have been included in the medication cycle since July 10th, 2023. The current order from the primary care provider indicates that the resident should be taking scheduled Atorvastatin 20mg and Losartan 50mg daily. However, there are no signs of these medications in the medication cart." On March 7, 2024, at 9:58 a.m., licensed practical nurse (LPN)-D stated the management staff called and said she was the one who discontinued the medication. She said if R1 missed the medication for three months, it must have occurred during her training period. She said she did not remember doing it or knowing anything about it. She further stated if the medications were delivered by the pharmacy, it was the responsibility of the registered nurse (RN) and an LPN to cross-reference them with the medical records. On March 6, 2024, at 3:02 p.m., Director of Nursing (DON)-A stated R1 was sent to the hospital for back pain, and it was then discovered that two of R1's medications, atorvastatin, and losartan, were discontinued three months ago by LPN-D without physician's orders. She said LPN-D had worked there for about a month when the order was discontinued. She discussed the	01760		

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 03/06/2024

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
01760	Continued From page 3 matter with LPN-D, who did not remember or know anything about it. LPN-D did not return to work as she had already submitted her notice. On March 6, 2024, at 3:02 p.m., (RN)-B stated LPN-D could have confused and discontinued the medication when the pharmacy continued sending confirmations through the system despite the orders already being in place. Following the incident, she contacted the pharmacy to find a solution to simplify the process and reduce confusion. She said even though the medications were discontinued on their system, The pharmacy's system still had those medication in R1's medical records. Therefore, the pharmacy kept sending the medication over, instead of verifying, the staff destroyed it. (RN)-B said it was the nurse's responsibility to check, and LPN-D failed to do so. She said they did not have any staff training session after this incident. On March 14, 2024, at 4:08 p.m., the pharmacy technician stated according to the records, the pharmacy delivered R1's Losartan and Atorvastatin every thirty days. R2 R2's face sheet indicated R2 admitted to the facility on June 6, 2022, with current diagnoses of atrial fibrillation, and hypertension. R2's service plan effective dated November 6, 2023, indicated R2 required assistance with medication management three times daily. R2's medication sheet indicated the following medications were missed on November 6, 2023, through November 9, 2023:	01760		

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 03/06/2024

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
01760	Continued From page 4 Eliquis 2.5 mg tablet one tablet by mouth twice daily Lasix 20 mg tablet one tablet by mouth once daily Isosorbide mono 30 mg tablet one tablet by mouth once daily Spironolactone 25 mg tablet one tablet by mouth once daily Atorvastatin 10 mg tablet one tablet by mouth every night at bedtime A review of the manufacturers website (https://www.eliquis.bmscustomerconnect.com) indicated do not stop taking Eliquis without talking to the doctor who prescribed it for you. For patients taking Eliquis for atrial fibrillation: stopping Eliquis increases your risk of having a stroke. R2's progress notes dated November 10, 2023, at 5:00 p.m. indicated R2 was assessed due to not receiving some of her medications for a few days. R2's right leg became swollen more than the left leg. R2 said it was sore. R2's progress notes dated November 12, 2023, at 12:03 p.m. indicated R2's speech slurred and could not open her eyes. R2 kept touching her head. R2's daughter was at the facility and advised staff to call 911. R2's hospital records dated November 12, 2023, indicated R2 was diagnosed with an acute cerebrovascular accident (CVA or stroke). The same documents indicated R2's speech was garbled with a sudden onset of aphasia. The records included imaging which indicated a "thrombus" (blood clot) associated with the CVA. On March 13, 2024, at 12:04 p.m., family	01760		

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 03/06/2024

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
01760	Continued From page 5 member (FM)-C stated she visited the resident three days after the resident was discharged from the hospital. She noticed the unlicensed caregivers had only given the resident Tylenol, so she inquired about the resident's other medications. Upon checking the medication cart, the unlicensed caregiver found the other medications present but not listed on R2's electronic medication administration record (EMAR). FM-C expressed concern R2 had missed her medications for three days, and the facility was unaware until her visit. Following a discussion with the management team, they promised to order an ultrasound to check for a blood clot, as the resident's right leg was swollen. However, the ultrasound would not be done until November 13, 2023. On November 12, 2023, the resident experienced slurred speech and had a stroke, prompting transfer to the hospital. FM-C said R2 was in intensive care unit for two days and discharged to transition care unit before she went back to facility. On March 6, 2024, at 4:09 p.m., LPN-E stated R2 was self-administered medications before being admitted to the hospital for a hip surgery. She said she was new at the time and did not realize she had to switch from self-administered to facility administered for the medication passers to see. On March 6, 2024, at 3:20 p.m., DON-A stated R2 was initially in the assisted living side and was transferred to the hospital for a broken hip after a fall. Upon discharge from the hospital, R2 was relocated to the enhanced care unit, which required more care. During her time there, the family observed that she did not receive all her medications and notified them. It was noted that she missed three days of medication.	01760		

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 03/06/2024

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
01760	Continued From page 6 Unfortunately, she returned to the hospital again on November 12, 2023, for slurred speech. On March 6, 2024, at 3:20 p.m., RN-B stated prior to R2's fall, she was self-administering medication. Upon R2's return, LPN-E did not realize the medications already in the system were set for self-administration and added new medications. The missed medications were the ones R2 used to take independently. When LPN-E processed the order, she failed to lift the button orders for the med passers to see. It was brought to RN-B's attention by a family member, and a registered nurse reviewed the situation. RN-B stated LPN-E had been working there for approximately a month when the incident occurred. After the incident, the provider was notified, and an ultrasound was ordered due to R1's red and swollen right leg. Unfortunately, R2 developed slurred speech and was promptly hospitalized before the ultrasound could be conducted. The licensee's Uniform Assessment Tool policy dated August 1, 2021, indicated for each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.	01760		

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 03/06/2024

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
01760	Continued From page 7 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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 two of two residents reviewed (R1, R2) was free from maltreatment. Findings include: Regarding HL355619950M involving R1 and HL355619485M involving R2 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 (POC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	