Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL355619950M
Compliance #: HL355618156C

Date Concluded: April 4, 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 alleged perpetrator (AP) neglected the resident by accidently discontinuing the resident's atorvastatin and losartan for three months.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The AP made an error and discontinued the resident's medications. However, the pharmacy continued to deliver the medication every thirty days, but the facility destroyed the medications without verifying if the medications had been discontinued for three months. The error was identified when the resident went to the hospital and the hospital attempted to reconcile the resident's medications.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff and pharmacy. 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 diagnoses included hyperlipidemia and hypertension. The resident’s service plan included assistance medications administration.

An incident report indicated the resident was sent to the Emergency Room (ER) due to a change in condition. The ER staff called to review the medications, and atorvastatin and losartan were not on the facility's list of medications. The facility initiated an investigation and found that a nurse discontinued the medications three months ago without doctor’s order. The same document indicated the pharmacy continued to send the medication(s) but the facility destroyed the medications as it did not appear on the resident’s medication list.

During an interview, the AP stated the hospital called regarding medications and informed the facility of what the resident had been prescribed. The facility said the resident was no longer taking those medications, specifically atorvastatin and losartan. The sated the hospital insisted the resident was supposed to continue with those medications and the facility initiated an investigation. The AP stated on the last day she worked at the facility, the facility called and said she was the one who discontinued the medication. She said if the resident missed the medication for three months, it must have occurred during her training and orientation time, and 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 and licensed practical nurse to cross-reference medication deliveries with the medical records. If she had found discrepancies, she would then inform her supervisor.

During an interview, manager #1 stated the resident was sent to the hospital for back pain, and it was discovered that two of the resident's medications, atorvastatin, and losartan, were discontinued three months ago by the AP without physician’s orders. She said the AP had worked there for about a month when the order was discontinued. She discussed the matter with the AP, who did not remember or know anything about it. The AP did not return to work as she had already submitted her notice.

During an interview, manager #2 stated the AP 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 the resident’s medical records. Therefore, the pharmacy kept sending the medication over, but the staff member(s) destroyed the medications without verifying the medications. It was the nurse's responsibility to check, and the AP failed to do so. She said they just conducted training after the incident with another resident, and then this incident occurred, so they did not have

another training session. She also reviewed the resident's medical record, noting that her blood pressure had not been elevated for the last three months without her medications.

During an interview, a pharmacy technician stated that according to the records, they delivered her medication every thirty days.

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

Action taken by facility:
Medication error documented in the tracking log. AP was taken off the schedule, and a vulnerable adult report was filed. The incident was discussed with the AP. The AP had already submitted her notice due to other concerns brought to her attention. Following this discussion, the AP did not return to work and no longer works here. The Regional Director followed up with the pharmacy regarding multiple changes that require nursing confirmation.

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 City 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 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.	