Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL203153006M
Compliance #: HL203155019C

Date Concluded: February 17, 2023

Name, Address, and County of Licensee Investigated:
The Prairie Lodge at Earle Brown
6001 Earle brown drive
Brooklyn Center, MN 5543
Hennepin County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Allegation #1 Finding: Not Substantiated

Allegation #2 Finding: Inconclusive

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):

Allegation #1: The alleged perpetrator (AP #1) neglected the resident when she failed to notify the nurse the resident was not receiving her diuretics (water pills) as prescribed to remove fluids. The resident only received the diuretic once day instead of twice, gained 15 pounds (lbs.) of fluid and required hospitalization.

Allegation #2: AP #2 abused a resident when she slapped the top of the resident's head.

Investigative Findings and Conclusion:

Allegation #1: The Minnesota Department of Health determined neglect was not substantiated. Although the resident's medications were missed, the error was an isolated incident. The

facility nurse assessed the resident, identified the weight gain, and sent the resident to the hospital, where he received treatment and returned to the facility.

Allegation #2: The Minnesota Department of Health determined abuse was inconclusive. While the resident reported he inadvertently brushed AP#2's leg with his walker to which she responded to slapping him on the head and walking away. However, the resident did not recall the date or time nor any witnesses to this incident.

Allegation #1

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigation included a review of the resident's records, both AP's personnel records, the facility's policies, and procedures, incident reports, and the resident's medical record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living facility. The resident's diagnoses are schizophrenia, heart failure, and anxiety. The resident's service plan included assistance with activities of daily living such as dressing, toileting, and bathing along with behavioral management. The resident ambulated with the use of a walker. The same documents indicated the facility provided medication management services.

The resident's medical records indicated his diuretic was increased from one a day to two times a day along with daily weights. However, the resident's electronic medication administration (EMAR) the resident did not receive the second dose for five days in a row.

The resident daily weights records indicated he had an approximately 15 lbs. weight gain.

The resident's medical records indicated he was sent to the hospital where he received intravenous diuretics to take fluids off and then returned to the facility.

During an interview, the clinical director the registered nurse notified her of the missed diuretic doses and the resident's increased weight. The clinical director stated it was unclear why the medication was not delivered from the pharmacy. The clinical director stated she asked AP#1 why she had not notified the registered nurse of the missing medication and AP#1 stated she did not know to do so. AP#1 told her she thought when she clicked on "notify pharmacy" in the EMAR the pharmacy would be notified. The clinical director re-educated AP#1 to notify a nurse if medication was not available for administration.

The registered nurse (RN)-C notified her about the resident's weight and his medication was not administrated per the physician's order. She confirmed she put the order in the system but was not sure why the pharmacy did not deliver it. She asked AP#1 why she did not notify her. AP#1

told her, she did not know she had to notify the nurse in person. She thought as she clicked "notified pharmacy" in the medication administration records (EMAR), the pharmacy would know. CD-A re-educated AP#1 to communicate with her about medication not being delivered.

During investigative interviews, the registered nurse stated she knew the resident had a new order for increased diuretic the previous week, so she wanted to check how he was doing and found out he gained 15 lbs. When she checked the EMR, she realized the resident had not been receiving the second dose of diuretic for a week. She confirmed took his vital signs right away and the physician. The resident told her he was feeling fine, however later he complained of shortness of breath and transferred to the hospital.

During an interview, the director stated the nurse should follow up to make sure the medications arrive, However, AP#1 was responsible to notify the nurse if the medication was not there.

During the investigation, the investigator attempted multiple times to interview AP#1 but without success.

The Minnesota Department of Health determined neglect was not substantiated

Allegation #2

During an interview, the resident stated he was walking on one occasion but became dizzy, so he leaned to one side and scraped AP#2 leg a little bit with his walker. The resident stated AP#2 then came along and hit his head several times. He was unsure if anyone else saw nor was he sure when this occurred.

During an interview, the director stated resident reported AP#2 slapped his head when he brushed by her legs. The director stated she investigated this matter by interviewing other residents who were there at those times, but no one recalled the incident. She said AP#2 had already resigned but was interviewed over the phone; AP#2 denied hitting the resident.

During an interview, AP#2 stated she never hit or slap any residents in her career. She also said she resigned from the facility due to personal reasons and she did not get fired.

The Minnesota Department of Health determined abuse was inconclusive.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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

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: Yes
Family/Responsible Party interviewed: No, resident was his own person.
Alleged Perpetrator interviewed: AP#1- attempts to interview were unsuccessful. AP#2 was interviewed.

Action taken by facility:
See actions described above. The facility did complete vulnerable adult reports to the state.

Action taken by the Minnesota Department of Health:

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.

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
	20315	A. BUILDING: _____ B. WING _____	C 01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRAIRIE LODGE AT EARLE BRO	6001 EARLE BROWN DRIVE BROOKLYN CENTER, MN 55430

(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 LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482/144G.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: #HL203155019C/#HL203153006M On 1/05/2023, 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 41 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL203155019C/#HL203153006M, tag identification 2320.	0 000	Minnesota Department of Health is documenting the State Licensing 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. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health	02320		

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02320	Continued From page 1 care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on the interview, and record review, the facility failed to follow up to ensure the medication was delivered and administered per the physician's order for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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's diagnoses included heart failure and schizophrenia. R1's service plan dated January 6, 2023, indicated the resident received services that included medication administration. R1's prescriber orders dated September 21, 2022, included an increase of Bumetanide to 2 milligrams (mg) twice a day and daily weights. R1's medication administration record (EMAR) indicated R1 did not receive his second dose of Bumetanide 2 mg from September 22nd to	02320		

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02320	Continued From page 2 September 26th, 2022. On January 10, 2023, at 4:18 p.m., the clinical director (CD)-A stated the registered nurse (RN)-C notified her about the resident's weight, and his medication was not administrated per the physician's new order. She confirmed she put the order in the system on the evening of September 21, 2022, but was not sure why the pharmacy did not deliver it the next day. She was not aware of the medication was not delivered. She asked the unlicensed personnel (ULP)-D who worked from September 22nd to September 26th why she did not notify her. The (ULP)-D told her, she did not know she had to notify the nurse in person. She thought as she clicked "notify pharmacy" in the EMAR, the pharmacy would know. CD-A re-educated the (ULP)-D to communicate with her about medication not being delivered. She said the resident was fine in the morning but was sent to the hospital later in the evening due to shortness of breath. On January 11, 2023, at 12:27 p.m., RN-C stated she was a float nurse, and she knew the resident had a new order for a diuretic last week. She wanted to check how he was doing and found out he gained 15 pounds since September 18, 2022. She checked the EMAR and realized he did not get his second dose per the physician's new order from September 22nd to September 26th, 2022. She confirmed she notified the physician right away and took his vital signs. The resident told her he was feeling fine. Later that night, he complained shortness of breath and was sent to the hospital for further evaluation. On January 11, 2023, at 2:40 p.m., the licensed assisted living director (LALD)-B stated the nurse should follow up to make sure the medication	02320		

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02320	Continued From page 3 arrives or not. The (ULP)-D also was responsible to notify the nurse if the medication was not there or something was wrong with the medication. The licensee's policy and procedure: Documentation of Medication, Treatment and Therapy Management Services dated August 1, 2021, noted the nurse will document actions to implement a new prescription when it is received, and actions to request and obtain needed refills for clients, including communications with the prescriber, pharmacy, client and/or client's representative or family. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		