Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL344599065M
Compliance #: HL344596666C

Date Concluded: December 23, 2023

Name, Address, and County of Licensee Investigated:
Praha Village, LLC
1100 1st Street SE
New Prague, MN 56071
Scott County

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

Evaluator's Name: Deb Schillinger, 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 facility neglected the resident when the resident was not sent to the hospital after a change in condition and later diagnosed with a mild stroke.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility nurse completed an assessment after notification from unlicensed staff of a concern, the nurse found no variation in condition and attributed change in condition related to increased fatigue. Unlicensed caregivers reported resident was up wandering during the night and resident's reporting she was tired. The facility nurse followed the facility procedure and the resident returned to baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family members. The investigation included review of the resident's medical records, the facility's policies and

procedures, incident reports, and staff schedules. Also, 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 Alzheimer's disease and dementia. The resident's service plan indicated the resident was able to walk with assistance and set-up assistance and reminders during meals. The resident's assessment indicated resident was oriented to self only with difficulty communicating needs due to impaired speech pattern.

The residents medical record indicated a progress note where the facility nurse documented notification of a concern the resident was more tired, talking slower with left sided drooping. The facility nurse assessed the resident and found the only deviation from the resident's baseline condition was increased fatigue. The facility nurse did re-assess the resident a second time and found the initial assessment unchanged. The facility nurse notified the resident's family at that time.

The resident's progress notes indicated the resident had an unwitnessed fall later the same day. The facility updated the resident's medical provider and spoke with the resident's family, who requested the resident transfer the hospital as she did not seem herself. The next day the resident remained in the hospital and had been diagnosed with mild stroke with left-sided weakness.

During an interview, the facility nurse stated she assessed the resident after an unlicensed caregiver reported the resident was not acting like herself. The facility nurse found the resident responsive, reporting was tired, but assessment was otherwise negative. The facility nurse reported the unlicensed caregivers ambulated with the resident to the noon meal where the resident consumed 100% of the meal without incident. The facility nurse stated she notified the resident's provider and family member and continued to follow up on resident's condition until she left for the day.

During an interview, the resident's family member reported she was working and received a call from the facility nurse relaying the resident condition. The family member stated she visited the resident later in the afternoon and knew something was wrong, an ambulance was called, and the resident was transferred to the hospital. The family member states the resident did have a mild stroke but is currently back at her baseline health condition.

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.
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;

Vulnerable Adult interviewed: No, due to cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action required.

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
	34459	A. BUILDING: _____ B. WING _____	C 12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAHA VILLAGE	1100 1ST STREET SE NEW PRAGUE, MN 56071

(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 December 12, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL344596666C/#HL344599065M. No correction orders are issued.	0 000		