Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL346013945M
Compliance #: HL346016570C

Date Concluded: April 25, 2023

Name, Address, and County of Licensee Investigated:
Prelude Homes and Services
10020 Raleigh Road
Woodbury, MN 55129
Washington County

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

Evaluator's Name:
Katie Germann, RN, Special Investigator

Finding: Inconclusive

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 a resident when the resident received an injury of unknown source to her left arm. In addition, the resident was neglected when the facility failed to administer the residents' antibiotics and inhaler according to physician orders.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident was found with bruising and skin tears on her left arm from an undetermined source. The resident was unable to say what caused the injury, and facility staff were unaware of how the injury occurred. It could not be determined how the injury occurred.
The resident was prescribed an inhaler to be administered as needed (PRN). The documentation indicated the resident received the inhaler when needed, and there was no indication the inhaler was administered incorrectly. The resident was prescribed an antibiotic which was not administered until three days after it was ordered. The facility identified the error, administered the full dose of the antibiotic to the resident, and the resident had no negative outcome.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, hospital notes, nursing notes, facility policies and procedures, homecare notes, medication administration records, employee records. The investigator completed onsite observations of resident care.

The resident resided in an assisted living memory care unit with diagnoses including Alzheimer's dementia, congestive heart failure, atrial fibrillation, and frequent falls. The resident required staff assistance with activities of daily living including dressing, bathing, grooming, meals, and medication management and administration. The resident had a history of falls and was at risk for falling due to dementia and functional impairments. Staff completed every two-hour safety checks to ensure the residents safety.

A facility incident report indicated the resident was found with an injury of unknown origin described as a grapefruit sized bruise on the left upper arm with two skin tears. There was no further information regarding how the injury occurred.

Nursing notes indicated staff discovered a bruise/abrasion on resident's left upper arm. The resident was unable to remember how the injury occurred, and staff were unaware of what could have caused the injury. The residents skin tears were cleansed with wound cleanser and a non-stick dressing was applied.

Nursing notes indicated later that day the resident's family member brought the resident to the emergency department to have the injuries on her arm looked at by a physician.

The emergency room notes indicated the resident presented at the hospital with complaints of a sore left upper arm. The resident had two, 3 centimeters (cm) x6 cm skin tears on the left triceps region (upper arm) with surrounding bruising that "looks old". The resident's skin tears were covered with bandages and follow up tests were performed including a head CT, an EKG (heart rhythm monitoring) and labs. The resident also received intravenous fluids and was released back to the facility.

The resident's primary provider notes nine days following the injury indicated the resident was to begin Duricef (an antibiotic) twice daily related to potential infection for the injury of unknown origin as the pain of the injury was increasing.

The resident's facility medication administration record (MAR) indicated the resident was administered the first dose of Duricef three days after the medication was ordered by the primary provider.

An outside report indicated staff were administering the resident's inhaler incorrectly and were touching the resident's tongue with the inhaler. There are no specific dates, times, or staff identified of when this occurred.

The residents MAR indicated the resident was prescribed an albuterol inhaler, two puffs every six hours as needed; and a Breo Ellipta inhaler, one puff into lungs one time daily. The resident received the Breo Ellipta inhaler daily as prescribed, and the as needed albuterol inhaler was administered twice.

The employee records indicated unlicensed staff were trained on administration of inhalers.

During interview, the facility nurse stated all staff were trained and observed on administration of inhalers. The nurse stated the resident's antibiotic was started three days after it was ordered due to the medication arriving on a weekend. The nurse stated if new medication orders arrive over the weekend staff are directed to contact the nurse so the orders can be implemented immediately. As soon as the nurse discovered the new medication order on Monday, the antibiotic was ordered and administered the same day. The nurse stated the resident was unable to say how she received the injuries. When staff were interviewed, they were unable to say what could have caused the residents injuries. The nurse stated they could not determine how the resident received the injury.

The residents medical record indicated the day prior, and the day of staff observing the resident's injury of unknow origin, all the residents cares were documented as completed according to the residents plan of care.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

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.

Vulnerable Adult interviewed: Deceased
Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
Staff re-educated on notifying nurse if new physician orders are received on the weekend and/ or when no nurse is at the facility.

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.
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34601	A. BUILDING: _____ B. WING _____	C 03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRELUDE HOMES & SERVICES, LLC	10018 RALEIGH ROAD WOODBURY, MN 55129

(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 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: #HL346016570C/ #HL346013945M On March 21, 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 52 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL346016570C/#HL346013945M, tag identification 2310.	0 000		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34601	A. BUILDING: _____ B. WING _____	C 03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRELUDE HOMES AND SERVICES	10018 RALEIGH ROAD WOODBURY, MN 55129

(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
02310	Continued From page 1 standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R1) reviewed for falls and an injury of unknown source. Facility nursing staff failed to ensure the source of the falls and injuries were investigated, and interventions were put into place to prevent falls and/or injuries from reoccurrence. 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). Findings include: R1's face sheet indicated the resident had diagnoses including Alzheimer's disease, atrial fibrillation, congestive heart failure, and frequent falls. R1's current assessment dated October 20, 2022, indicated R1 was impulsive which could contribute to falls and injury risk factors. The assessment indicated the resident required staff assistance with activities of daily living including bathing, dressing, grooming, meals, laundry, and medication management and administration. The resident had safety checks scheduled every two	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34601	A. BUILDING: _____ B. WING _____	C 03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRELUDE HOMES AND SERVICES	10018 RALEIGH ROAD WOODBURY, MN 55129

(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
02310	Continued From page 2 hours. An incident report dated October 22, 2022, indicated, the residents family member called the facility and told them R1 was on the floor and staff needed to go to the residents room and assist her. The family member had a camera in R1's room and reported to staff she observed the resident slide out of the recliner and onto the floor, but did not hit her head. Staff went to R1's room and observed the resident lying on the floor. The incident report indicated the nurse was notified. The incident report lacked any further follow up regarding the fall, and the action taken was documented as, "more safety checks". There was no corresponding documentation increased safety checks were implemented. R1's progress notes dated October 22, 2022, indicated R1's family member called the facility to inform them she was transporting R1 to the emergency room due to the fall earlier that day. R1's progress notes dated October 24, 2022, indicated R1 was admitted to the hospital for dehydration following the fall on October 22, 2022. R1's incident report dated November 8, 2022, titled, "injury of unknown origin", indicated R1 was found with an orange sized bruise and skin tear on her left hand. The resident was unable to state what happened and staff indicated the did not know how the resident got the injury. The incident report indicated the nurse was contacted, however, there were no follow up notes and/ or assessments regarding interventions that could be implemented to prevent injuries from reoccurring.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34601	A. BUILDING: _____ B. WING _____	C 03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRELUDE HOMES AND SERVICES	10018 RALEIGH ROAD WOODBURY, MN 55129

(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
02310	Continued From page 3 R1's incident report dated November 9, 2022, titled, "injury of unknown origin", indicated R1 had been found to have a bruise and two skin tears on her upper left arm. R1's progress notes dated November 9, 2022, indicated staff found a bruise/abrasion on resident's left upper arm. The resident was unable to remember what happened, and staff were not aware of how the injury occurred. R1's skin tears were cleansed with wound cleanser and a non-stick dressing was applied. The progress notes indicated an email was sent to the residents family member to notify them of the injury. In addition, the facility asked the family member to review the recorded video footage from the evening prior and to notify the facility if there were any falls or if the resident may have "bumped arm". No new interventions were put into place to prevent reoccurrence of injuries. R1's incident report dated December 2, 2022, titled "other incident (non-fall)" indicated R1's family member called the facility and stated she observed the resident (on camera) fall in her room. Staff went to R1's room and the resident was seated on the chair. The staff assisted the resident to bed per request of the family member. The incident report indicated the action taken to prevent reoccurrence was "safety checks". There was no indication there were any changes to the residents plan of care to increase or change the way safety checks were completed. During interview on March 21, 2023, at 12:30 p.m., registered nurse (RN)-B stated she had no further documentation regarding any further assessments, investigations, or interventions to	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34601	A. BUILDING: _____ B. WING _____	C 03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRELUDE HOMES AND SERVICES	10018 RALEIGH ROAD WOODBURY, MN 55129

(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
02310	Continued From page 4 prevent falls and ongoing, unknown injury's. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		