Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Project: HL346016943M
Compliance Project: HL346011483C

Date Concluded: January 31, 2025

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: Deb Schillinger RN BSN, 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 plan of care was not followed, and the resident fell sustaining a fractured femur (thigh).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell and sustained a fractured femur, the facility had appropriate interventions in place to reduce the risk of falls including frequent checks on the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record, death record, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed facility staff and resident interactions during an onsite visit.

The resident lived in a memory care unit. The resident's diagnoses included Alzheimer's disease and osteopenia (low bone density). The resident's service plan included assistance with mobility and safety checks along with a tab alarm, which had scheduled checks the alarm was set up. The assessment indicated the resident had an increased risk for falls, was cognitively impaired and required standby assist when ambulating with a walker.

The resident's medical record indicated the resident was found on the floor after an unwitnessed fall, approximately 30-45 minutes before the evening meal. The unlicensed caregivers notified the nurse, then the resident was transferred by emergency medical services to the hospital and found to have a fractured femur.

The resident had a personal alarm in use that was activated if the resident attempted to self-transfer. During the onsite visit associated with this investigation it was observed that the alarm did not go off in the resident's room, but rather at a nurse's desk located elsewhere on the memory care unit. Additionally, the investigation determined the facility had a practice at shift-change in which both the outgoing and the oncoming shift would check each resident although this check was not specially scheduled in the residents' care plans.

The facility had two different types of checks scheduled for the resident.

- A personal alarm check which was scheduled near the end of each shift (day, evening, and night).
- A safety check one half-hour after the start of each shift.

The report of delivered services by unlicensed caregivers indicated the personal alarm check was documented as completed near the end of the day shift.

The report of delivered services by unlicensed caregivers indicated unlicensed caregiver #1, who later found the resident on the floor, documented completion of this check prior to the resident's fall.

During an interview, unlicensed caregiver #1 stated she started her shift 30 minutes late and was told the end of shift count and walking rounds were already completed. Since she was starting her shift a bit late, she checked on all the residents in her assignment, which included the resident. Caregiver #1 stated she checked in the resident's room and greeted the resident; but did not check to see if the tab alarm was under the resident. The unlicensed staff member stated she continued to check the other residents assigned to her. About an hour later, the resident was heard calling out and was found on the floor in her room.

During an interview with unlicensed caregiver #2, who worked the evening shift with caregiver #1, stated she completed the change of shift rounds with the previous day shift that was ending although she did not specifically recall the personal alarm was on the resident at that time.

During an interview, a nurse stated she was called after resident was found on floor, who was complaining of pain in the thigh area, and so the resident was transferred to the hospital via emergency medical services. The nurse stated that when she checked to see if the personal alarm was activated at the nurses station it was not, however she acknowledged someone might have turned it off prior to her arrival.

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;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: No. The resident was deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: The facility made changes to its shift-change process more specific direction and documentation on personal alarm checks.

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
	34601	A. BUILDING: _____ B. WING _____	C 01/08/2025

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
0 000	Initial Comments On January 8, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL346011483C/#HL346016943M. No correction orders are issued.	0 000		