*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL216427707M
**Compliance #:** HL216424526C

**Date Concluded:** September 27, 2023

**Name, Address, and County of Licensee Investigated:**
Vista Prairie at Windmill Ponds
715 Victor Street
Alexandria, MN 56308
Douglas County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:**
Jana Wegener, 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 when they failed to implement prescribed orders for furosemide (a diuretic medication) for seven days. The resident developed weeping wounds on her lower extremities, was transferred to the emergency department, and was admitted to the hospital.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to implement prescribed furosemide orders or identify a medication error for nine days. In addition, the facility failed to provide care, services, and monitoring of the resident's edema including applying the residents' ace wraps daily. As a result, the resident developed weeping wounds with malodorous green drainage and severe pain. The resident was transferred to the emergency department and admitted to the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's provider and pharmacy. The investigation included a review of resident records including medication and treatment administration records (MAR/TAR), medication reports, assessments, progress notes, service plan, service delivery record, after visit summaries, provider orders, staff communication, facility investigation documentation/interviews, facility policies and procedures, and pharmacy documentation.  Also, the investigator observed other residents in the facility, and the facility medication and orders implementation system.

The resident resided in an assisted living facility with diagnoses including hypertension, and gout. The resident's admission assessment indicated the resident was alert oriented and able to make her needs known. The admission assessment indicated the resident required no treatment or therapies and had no pain on admission.

The resident's service plan indicated the resident required assistance with medication management and administration. The service plan included assistance with bathing weekly and instructed staff to notify the nurse regarding any concerns including open areas, redness, and swelling. The resident record indicated the resident received bathing assistance but lacked any documentation of staff reporting concerns with the resident's skin.

The resident's MAR/TAR indicated the resident was prescribed furosemide (a diuretic medication) 40 milligrams (mg) daily in the morning for essential primary hypertension on admission.

Nine days after the resident was admitted to the facility an after-visit summary (AVS) indicated the resident was seen in the emergency department (ED) for swelling and edema of her lower legs and ankles. The AVS indicated the resident received intravenous Lasix (a diuretic medication used to remove excess fluids from the body) and had dressings and ace wraps applied to her lower legs that would need to be changed. The AVS indicated the ED provider prescribed an additional dose of furosemide 40 mg in the morning, and 20 mg in the evening for the next two days. The AVS indicated the resident should follow up that week for a re-check and labs. There was no indication the resident was seen for a recheck or labs as directed.

A facility post ED resident assessment identified the resident required assistance with dressing changes and treatments; and new orders were received for ace wraps to be applied daily. The assessment identified the resident had weeping open areas. However, the resident record including MAR/TAR, and service agreement failed to include orders for the daily dressing changes/ace wraps, or assessment and monitoring of the resident's legs, edema, or open areas.

A review of the resident's physician orders included orders to administer an additional 40 mg of furosemide in the morning, and 20 mg at bedtime for the following two days.

A review of the resident's MAR indicated the order was never implemented and the resident did not receive the additional dose of furosemide as prescribed.

A medication entry detailed report indicated the day after the additional two-day furosemide order was supposed to end the AP discontinued the residents daily 40 mg dose of furosemide in error. As a result, the resident did not receive the additional dose of furosemide for two days, and then received no furosemide as prescribed for the next seven days.

A pharmacy delivery slip dated the same day as the physician's order, indicated the two-day furosemide medication order was filled by the pharmacy, delivered to the facility, and was signed as received by facility staff. However, the facility failed to identify the medication had not been implemented.

A review of the resident's progress notes, and staff communication included documentation of the resident being seen in the ED for swelling and weeping of her lower legs, and indicated the resident was prescribed additional furosemide for two days, however the order was not implemented. The progress notes included multiple entries of the resident having increased pain, swelling, and weeping in her legs. Eight days later another progress note indicated the resident's legs continued to be weeping, swollen, required frequent ace wrap changes, and mentioned the resident had open areas on her legs. However, the resident record lacked documentation of dressing changes being completed, or assessment and monitoring of the resident's edema or open areas to identify and prevent a worsening condition.

11 days after the resident was seen in the ED with orders for dressing/ace wrap changes daily the resident was seen in the facility by her provider. A progress note indicated the resident had open areas on both legs with malodorous green drainage. The first and only measurement of the resident's open areas indicated at the time the resident's open areas measured 15 centimeters (cm) by 9 cm on the right shin, and the left leg had a red area measuring 7cm by 5 cm with an open area in the middle. The note indicated the resident's legs were painful.

When interviewed the resident's provider stated the facility should have been doing dressing changes and monitoring the resident's edema. The provider stated when he saw the resident her leg dressings were saturated with drainage, and the dressings appeared to have not been changed for some time because green bacteria was observed growing on the outside of the resident's gauze dressings. The provider stated he questioned if the resident received her furosemide, and when the nurse checked her MAR, it was discovered that she had not received the additional dose of furosemide as prescribed, or her regular scheduled furosemide for the last seven days.

The following day a progress note indicated the resident was seen by wound care, the resident was diagnosed with a cellulitis infection, prescribed pain medication, and dressing changes four times daily. Three days later a progress note indicated the resident was seen by wound care

who recommended the resident follow up with the ED. The resident was admitted to the hospital and discharged to another facility on end-of-life hospice care.

When interviewed unlicensed facility staff stated the resident's legs were weeping, and they would re-secure the dressings if they came loose or undone, but stated the nurse took care of the resident's dressings. Staff stated they would complete dressing changes if assigned to their task list on the resident MAR for that shift.

The resident's services task list failed to include dressing/ace wrap changes.

A licensed staff stated they were aware the resident had returned from the ED with dressings and wraps on her legs but indicated they were not sure if anyone was changing the resident's dressings, or if facility staff were even supposed to. The staff stated unlicensed staff tried to keep the dressings intact, and indicated the dressings applied in the ED were never removed. The licensed staff stated when the resident's provider saw the resident during rounds the dressings on her legs were saturated, dripping wet, smelly, and had green discharge.

When interviewed the AP stated she was cleaning up the resident's MAR and deleted what she thought was the two-day furosemide order, however, she discontinued the resident's daily furosemide in error.

Facility cooperate leadership stated all licensed nurses have access to see pending orders that need to be processed for all residents in the facility, yet no one questioned why the resident's two-day furosemide order was not implemented. The leadership staff stated when the resident's daily furosemide order was discontinued in error, and after the additional furosemide two-day prescription was delivered to the facility, multiple staff over 10 days would have seen the resident's furosemide available with no orders to administer the medication, but no concerns were ever reported. The leadership staff stated the resident's orders, assessment, and service plan should all align and indicated that did not happen to ensure the resident's dressing/ace wraps were changed and the residents' wounds were monitored.

When interviewed the resident's responsible party stated the resident was admitted to the facility with dressings and ace wraps, and indicated the facility was supposed to be changing her dressings. The responsible party stated she was not informed of any medication errors with the resident's furosemide.

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, deceased
**Family/Responsible Party interviewed**: Yes
**Alleged Perpetrator interviewed**: Yes

**Action taken by facility:**
The facility reported the concern to the Minnesota Adult Abuse Reporting Center. Investigated the concern, then implemented new processes to ensure orders are implemented and safe accurate medication/treatment administration services are provided. Education was provided to staff to ensure compliance with providers orders.

**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
Douglas County Attorney
Alexandria City Attorney
Alexandria Police Department

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21642 | A. BUILDING: _____ B. WING _____ | C 09/11/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VISTA PRAIRIE AT WINDMILL PONDS | 715 VICTOR STREET ALEXANDRIA, MN 56308 |

| (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<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL216427707M/ #HL216424526C, and #HL216426143M/ #HL216421565C.<br><br>On September 11, 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 61 residents receiving services under the provider's Assisted Living license.<br><br>The following order is issued for #HL216427707M/ #HL216424526C, tag identification 2360. | 0 000 | The Minnesota Department of Health documents the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the Surveyors and/or Investigators ' findings is the Time Period for Correction.<br><br>Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the state correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys and/or complaint investigations.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 0 000 | Continued From page 1 | 0 000 | THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPY AND LEVEL ISSUED PURSUANT TO THE MINN. STAT. § 144G.31, SUBDIVISION 2 and 3. | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure one of one residents (R1) were free from maltreatment. R1 was neglected.<br><br>Findings include:<br><br>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility.<br><br>Please refer to the public maltreatment report for details. | 02360 | | |