Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Project: HL307037862M
Compliance Project: HL307033680C

Date Concluded: February 25, 2025

Name, Address, and County of Licensee Investigated:
Vista Prairie at North Pointe
2135 Lor Ray Drive
North Mankato, MN 56003
Nicollet County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lena Gangestad, RN
Special Investigator
Paul Spencer, 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 facility neglected the resident by failing to follow up on the family's request to check on the resident when his legs were swelling. Additionally, the facility did not follow up or notify the head nurse that the resident had gained 20 pounds (lbs.) within two weeks.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Between the resident's admission and hospitalization approximately a month later for congestive heart failure which required diuresis to treat, the resident gain more than 20 lbs. The facility neither set up nor offered interventions to monitor his fluid status such as scheduled weight checks.

Additionally, regarding the weights the facility did obtain, it did not follow up on those. When the resident developed shortness of breath, family took him to the urgent care for treatment.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, internal investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living facility. The resident's diagnoses upon admission included dementia, atherosclerotic heart disease, and hypertensive chronic kidney disease. The resident's service plan included assist with medication administration and wellness checks three time a day.

A concern arose the resident had a weight gain of over 20 lbs. from possible fluid retention from the resident's admission to the facility to his hospitalization approximate one month later. Eventually, the resident developed shortness of breath, admitted to the hospital, and required diuresis (removal of excess fluids) as part of his treatment.

The admission assessment indicated the assessment was completed in the resident's home and was completed a day before the resident admitted to the hospital. The same document listed the resident's weight as 151 lbs. but does not clarify if the weight was obtained in the resident's home or how.

The progress notes indicated the resident admitted the following day because his main caregiver was not available, and the admission was for respite care in the meantime.

Upon admission, the prescribed medications indicated torsemide 10 milligrams (mg) was prescribed (a medication used to treat fluid retention and swelling due to causes including kidney disease).

A review of the admission orders from the medical provider included an order for torsemide but did not include the associated diagnosis on the admission paperwork.

The EMAR indicated listed the reason for torsemide as atherosclerotic heart disease.

A review of the resident's medical record did not identify documentation indicating the facility initiated or offered scheduled weights to monitor the resident's fluid status.

Approximately two weeks after the resident admitted to the facility, the facility completed a 14-day assessment which included a weight of 176.4 lbs. A review of the resident's medical record did not identify any other weights obtained by the facility since the day of admission.

Approximately one month after the resident admitted to the facility, one of the resident's family members visited and noticed that the resident was having trouble breathing. She took him to urgent care, and he was subsequently transferred to the emergency room.
The resident's hospital records indicated that he was admitted for congestive heart failure. He underwent diuresis (removal of excess fluids), resulting in a net loss of 4.6 liters of fluid from his body using intravenous Lasix (a diuretic). Additionally, the hospital records indicated torsemide was increased to 20 mg daily (from 10 mg) upon discharge several days later. The resident did not return to the facility.

The investigation included a request of the list of the weights obtained by the facility. The facility listed three weights

- One weight for the day of admission, 151 lbs., which matched the result listed on the assessment dated the day before. However, it was unclear whether this was the same weight or if the weight was obtained at the facility itself.
- A second weight, 176.4 lbs., which matched the assessment completed about two weeks after the resident admitted.
- A third weight, 183.6 lbs., which was dated approximately two weeks after the second weight and one day prior to the family member taking the resident to urgent care and his subsequent hospitalization.

A review of the resident's medical record as provided by the facility did not identify of documentation of the facility taking notice of the resident's weight gain nor if the facility took any specific actions to follow-up.

A review of the resident's medical record indicated two different nurses employed by the facility completed the admission assessment and the 14-day assessment, respectively.

During an interview, a family member stated she and her husband visited the resident and noticed that his legs were significantly swollen. The family member stated told the resident to notify the nurse to weigh him to determine if he was retaining fluid. The family member said the resident told her she had spoken with a nurse for over a week, but nothing had been done. The family member stated on the day prior to the taking the resident to urgent care, she spoke with an unlicensed caregiver who did weigh the resident. That same night the resident fell. The next morning, the family member visited the resident, found he was short of breath and subsequently took him to urgent care.

During an interview, an unlicensed caregiver stated the resident's family was concerned about his leg swelling and wanted the nurse to check on him. The unlicensed caregiver stated she relayed the message to a nurse but did not know what happened after that. The unlicensed caregiver the family asked her to weight the resident on another occasion, so she did.

During an interview, a nurse stated she and her supervisor, who was also a nurse, split the 14-day assessment, and she could not remember whether she had completed the resident's

14-day assessment. The nurse stated she did not recall a fellow employee informing her of concerns raised by the resident's family. However, she did remember the resident's family talking to her about concerns but was unsure when that occurred.

During an interview, a supervisor, who was also nurse, stated the facility was unaware the family had taken the resident to urgent care or the emergency room although the resident's family called later that day to inform them. The supervisor stated there had been no prior indication to her or the facility regarding the resident's weight until the day he was hospitalized. The supervisor stated an unlicensed caregiver had notified the facility nurse on the day he went to urgent care, but the facility nurse did not follow up with it. The supervisor stated the weight gain could have been identified at the time of the second assessment by checking in the electronic medical record under the health monitoring tab.

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, the resident had dementia.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: The facility conducted an internal investigation and provided education and/or corrective action for the persons involved. The nurse was no longer employed at the facility at the time of the investigation.

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
Nicollet County Attorney
North Mankato City Attorney
North Mankato Police Department
Minnesota board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE AT NORTH POINTE	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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 16, 2025, the Minnesota Department of Health initiated an investigation of complaint: No correction orders are issued for HL307038162M/HL307034343C. For HL307037862M/ HL307033680C: The following correction order is issued, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment 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. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: 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. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	