Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307038162M
Compliance #: HL307034343C

Date Concluded: February 21, 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

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 he was found unresponsive in his recliner chair, which was saturated with urine and feces. At the hospital, the resident was found to have developed new skin concerns including a pressure injury and dermatitis.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While it was true the resident became acutely ill, the facility sought care appropriately. It was also true the resident was found incontinent, which may have contributed to his dermatitis, however the resident's medical record indicated the facility was assisting the resident obtain a barrier cream, which would reduce this risk. The resident developed a small pressure injury on his heel, however the resident slept in a recliner chair, which increased the risk for such an injury and his illness may have changed his ability to self-position in his recliner.

The investigator conducted interviews with facility administrative staff. The investigation included review of the resident's records, incident reports, staff schedules, policies, and procedures.

The resident resided in an assisted living facility. The resident's diagnoses Parkinson's disease and type 2 diabetes. The resident's service plan included assist of two persons with EZ stand with mobility. The resident was incontinent of bowel and bladder and wore incontinence brief; he used a urinal but required assistance to empty. The resident required an EZ-stand lift along with the assistance to two caregivers for transfers and received escorts to meals.

The service plan also indicated the resident needed assistance with dressing, grooming, and incontinence cares. The assessment indicated the resident required assistance with repositioning, slept in his recliner, and was able to make slight position changes to shift his weight. The resident's service plan indicated the resident had incontinence care and toileting care scheduled in the morning, afternoon, overnight and as needed. It also indicated the resident had scheduled for bathing provided weekly by home health care agency.

A concern arose that the resident was found unresponsive and incontinent of both bowel and urine. Due to the change in status the resident was transferred to the emergency room, where a concern for the resident's skin was identified.

Six days prior to this event an assessment conducted indicated the resident had no identified skin issue. The assessment also indicated the vital signs were normal and no lung sound was documented. However, the progress notes indicated the facility was trying to obtain a barrier cream for the resident, but insurance would not cover the product, so an alternative product was being requested. (A barrier cream product was designed to guard against skin irritation and infection).

The progress notes indicated an unlicensed caregiver entered the resident's room and found the resident with facial drooping and unable to follow directions. The same document indicated a set of vital signs were taken which indicated the resident had a fever and low oxygen levels. The facility transferred the resident to the emergency room.

In the emergency room (ER), he exhibited a fever, cough, confusion, and worsening respiratory distress and hypoxia. His oxygen needs progressively worsened, eventually requiring a high-flow nasal cannula at 6 liters per minute and 95% FiO2 (Fraction of Inspired Oxygen). Due to the resident's overall condition, the decision was made to intubate him and admit him to the ICU for further management. The record also indicated that the resident had soiled himself with stool and urine, with multiple rashes and pus around the genital area. The resident's hospital record indicated that he was admitted due to influenza with pneumonia.

The hospital record indicated the resident had intertrigo dermatitis (a common inflammatory skin condition in areas where skin rubs together) located on the abdomen, groin, and scrotum.

The same records indicated right heel pressure injury which was black and purple measuring 3 centimeters (cm) by 1 cm although the wound was not open.

During an interview, the manager, who was also the nurse, stated that when she conducted the resident's 14-day assessment, she laid him down to check his skin from head to toe and did not observe any skin concerns at that time. She also stated that she checked his vital signs and listened to his lung sounds. The vital signs were normal, and the lung sounds were clear.

During an interview, the resident and the family member expressed no concerns about the care he was receiving at the facility.

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.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action taken.

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
	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.	