Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL216422161M
Compliance #: HL216423869C

Date Concluded: September 13, 2022

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Jill Hagen, RN,
Special Investigator

Finding: Not Substantiated

Nature of Visit:
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 had a decline in condition, the resident's room was in disarray, and the facility failed to ensure interventions were in place to assist the resident. The resident developed pressure ulcers, required hospitalization because of his declining health, and later died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident fell and had a rapid decline in health status. The facility added services and arranged for the

resident to be evaluated at a local hospital. There was no evidence the resident developed pressure ulcers. The residents medical record and staff interviews indicated the resident's room was cluttered and in disarray at times related to the residents wishes. However, the allegation does not meet the definition of neglect.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's case worker and Adult Rehabilitative Mental Health Services (ARMHS) worker. The investigation included review of the resident's hospital and medical record, staff schedules, and facility policies and procedures. The investigation included an observation of the facility and the resident's apartment.

The resident resided in an assisted living facility with diagnoses that included a previous stoke, chronic obstructive pulmonary disease, and Parkinson's disease. The resident made his needs known to staff. The resident's service plan included cues and assistance with dressing, grooming, bathing, medication management, wellness checks every two hours, housekeeping, and meal preparation. The resident used a wheeled walker to assist with ambulation and/or an electric scooter when out in the community.

A progress note indicated when out in the community the resident had a witnessed fall, hit his head, and had bruising to the left temple, eye, hip, and an abrasion to the left elbow. Emergency personnel assessed the resident however, at that time the resident refused further care from emergency personnel or his provider.

Eleven days after the fall, the resident "was not himself" and staff arranged for an evaluation at a local hospital. The resident required transport to a higher level of care and was diagnosed with two areas of brain bleeding. The resident returned the same day to the facility with orders to stop Plavix and Aspirin (both used as blood thinners) and repeat a CT scan of the resident's head in two weeks.

Eight days later the resident had lost weight with decreased appetite, nausea, and increased weakness. The resident began spitting out evening medications, refusing nebulizer treatments, and had difficulty swallowing. The facility notified the provider who ordered a follow-up CT scan, Zofran (anti-nausea medication), a standard wheelchair, hospital bed, and speech therapy for swallowing difficulties. That evening, the resident was evaluated at a local hospital and returned to the facility with an order for hospice, thickened liquids due to aspiration, and an increase in care.

One day later, a contracted hospice provider assessed the resident and determined the resident required a higher level of care. The resident was transported to a hospital for an evaluation and was admitted to a hospital.

The hospital record indicated the resident initially had signs of agitation and restlessness that gradually resolved. The resident became more withdrawn during his hospitalization with failure to thrive, minimal to no oral intake, refused cares and therapies, with significant somnolence (drowsiness) and fatigue. The hospital record indicated the resident's skin was intact without pressure ulcers. The resident chose comfort care and eventually discharged to another facility with hospice.

During an interview, the hospice nurse stated when she entered the resident's apartment in the early afternoon, the apartment was in disarray, the resident was in bed moving back and forth wearing a T-shirt and incontinent product, soiled chux were on the floor next to the bed, the mattress was soiled with dry and wet urine, the bathroom toilet was dirty, there was old food in Styrofoam containers on the resident's counter, and the resident was confused. The nurse stated the resident agreed to be evaluated at a local hospital.

During interview, unlicensed personnel stated the resident's apartment was cluttered because he enjoyed collecting items. The resident preferred to throw his own garbage. The ULP stated the resident preferred to lay in bed without clothes and sometimes without an incontinent product. The resident was able to remove his clothes right after staff assisted him to dress. The resident independently used the toilet unless he requested assistance. The unlicensed staff stated the resident often "missed the toilet" and it was difficult for housekeeping services to keep the resident's bathroom clean. During the residents last week at the facility, the resident frequently refused to eat so staff brought food to his room in Styrofoam containers. The unlicensed staff stated the last few days at the facility, the resident refused to eat and drink, refused medications, and often choked.

During an interview, management stated the resident's condition changed quickly and the facility increased services arranged for the resident. Care and services were provided to the resident as he allowed. Management stated the facility staff did not obtain a residents' weight unless ordered by the residents' provider. When management realized the resident had lost over 20 pounds in four months, management scheduled weekly weights for the resident and the provider ordered a nutritional supplement. The resident required admission to the hospital prior to initiating the provider orders.

Review of the resident's certificate of death indicated natural causes as the primary cause of death.

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: No, deceased.
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:
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.

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
	21642	A. BUILDING: _____ B. WING _____	C 08/23/2022

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 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: #HL216423869C/#HL216422161M On August 17, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 50 residents receiving services under the provider's Assisted Living license. The following immediate correction order is issued for #HL216423869C/#HL216422161M, tag identification 0510. The immediacy was removed for tag identification 0510, on August 23, 2022, when onsite observations and document review indicated the facility implemented infection control practices.	0 000	The Minnesota Department of Health documents the State Licensing 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 ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	

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0 000	Continued From page 1 The following correction orders which are not immediate are issued for #HL216423869C/#HL2167422161M tag identification 1620 and 2310.	0 000		
0 510 SS=I	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19 regarding wearing appropriate personal protective equipment (PPE). This had the potential to affect all 50 residents, staff, and visitors. An immediate correction order was issued when facility staff were observed without eye protection and the facility was in a county with a high transmission rate of COVID-19. The facility also had a recent staff member test positive for COVID-19, worked while infectious, and the	0 510		

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0 510	Continued From page 2 facility was currently completing COVID-19 outbreak testing facility wide. The immediacy was removed on August 23, 2022, when onsite observations and document review indicated the facility implemented infection control practices which comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: The Minnesota Department of Health (MDH) guidance titled, COVID-19 Personal Protective Equipment (PPE) and Source Control Grids dated April 7, 2022, indicated health care workers working with residents with or without suspected or confirmed SARS-CoV-2 (Covid-19) wear a face mask and eye protection in communities with substantial and high community transmission levels. On August 17, 2022, at 12:15 p.m., the surveyor observed Registered Nurse (RN)-A, Licensed Practical Nurse (LPN)-D, and the facility COVID-19 screener at the front door of the facility wearing surgical grade face masks but no appropriate eye protection.	0 510		

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0 510	Continued From page 3 On August 17, 2022, at 1:45 p.m. three staff were observed wearing surgical grade masks without appropriate eye protection. During an interview on August 17, 2022, at 12:45 p.m. RN-C stated the licensee was currently providing outbreak testing for COVID-19 due to one staff who tested positive for COVID-19 and exposed residents when infectious. RN-C stated currently staff were not required to wear eye protection, and RN-C was not aware of the high transmission rate of COVID-19 in Douglas County. Review of the MDH Situation Update for Covid-19, updated August 17, 2022, indicated Douglas County had a high transmission rate. Time Period for Correction: Immediate.	0 510		
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90	01620		

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01620	Continued From page 4 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment following a change in condition for one of one (R1) residents reviewed. R1 had significant weight loss and following a fall, developed an inability to swallow, choking and nausea. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: Review of R1's facesheet indicated R1's diagnoses included a previous stroke, Parkinson's disease, and chronic obstructive pulmonary disease (COPD). R1's most current assessment dated May 25, 2022, indicated R1 required staff assistance and/or supervision with dressing, grooming, bathing, ordering incontinent products, was	01620		

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01620	Continued From page 5 independent with transfers, eating, and used a walker to assist with ambulation. R1's service agreement dated June 3, 2022, indicated R1 required staff supervision to dress, groom, and one staff to assist with medication management, laundry, housekeeping, and meal preparation. R1 was independent in ambulation using a walker, transferring and eating. A progress note dated June 22, 2022, at 3:13 p.m. indicated on June 19, 2022, R1 fell when out in the community at a restaurant. R1 hit his head, left elbow, and left hip. Emergency medical personnel responded to the restaurant to assess R1. R1 denied the need to be transported to a hospital or be evaluated by his provider. A progress note dated June 30, 2022, at 8:54 a.m. stated R1 was brought to the emergency room (ER) this morning. A progress note dated June 30, 2022, at 9:51 a.m. stated R1 was transferred to a higher level of acute care hospital with two brain bleeds from his last fall. A progress note dated July 1, 2022, at 10:48 a.m. stated, R1 returned from the hospital last evening with orders to hold Plavix and Aspirin (blood thinners) for two weeks due to subdural (blood of the surface of the brain) bleeding. A progress note dated July 8, 2022, at 11:35 a.m. indicated R1 had seven falls from March 2, 2022, through June 19, 2022, hitting his head with each fall. When sent to the ER on June 30, 2022, for "not being himself" R1 was diagnosed with two brain bleeds. Orders received to hold Plavix and Aspirin and repeat a CT scan of R1's head in two	01620		

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01620	Continued From page 6 weeks. R1 tested positive for Covid-19 when in the ER. R1 lost weight, had increased nausea, a decreased appetite, and increased weakness. R1 started spitting out his evening medications, refusing nebulizer treatments, and started having difficulty swallowing. A progress note dated July 12, 2022, at 9:41 a.m. stated, on July 11, 2022, R1 was seen a provider with orders for a CT scan, nutrition supplements for weight loss, Zofran (anti-nausea medication), a regular hospital bed, a standard wheelchair, and speech therapy for a swallowing study. R1's family requested an evaluation of R1 in the ER on July 11, 2022, for increased confusion and difficulty swallowing. A CT scan revealed the previous brain bleeds had slightly increased in size. R1 was diagnosed with dehydration and aspiration of thin liquids. The ER provider ordered thickened liquids and an increase in nursing care. R1 returned to the licensee. A progress note dated July 13, 2022, at 10:39 a.m. stated, R1 would be admitted to hospice. A progress note dated July 13, 2022, at 2:39 p.m. stated, hospice and R1's county case manager (CCM)-D were in for an assessment of R1. R1 qualified for hospice but required a higher level of care than provided by the licensee. R1 was transported to a local hospital and was unable to return to the licensee due to the need for the higher level of care. A progress note date July 18, 2022, at 12:34 p.m. indicated it was a late entry for May 25, 2022, and the Director of Health Services (DHS)-A completed a 90 assessment in R1's room. R1 denied issues at at time.	01620		

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01620	Continued From page 7 During an interview on August 26, 2022, at 3:10 p.m. R1's CCM-D stated she visited R1 at his apartment on July 7, 2022, to complete a county reassessment. CCM-D had last seen R1 six months prior and was shocked by the amount of R1's weight loss. CCM-D asked staff for a current weight, however, the last weight of 142 pounds was completed on March 10, 2022. On July 11, 2022, R1's weight was 118 pounds (a loss of 24 pounds in four months). During an interview on August 30, 2022, at 12:40 p.m., the hospice Registered Nurse (RN)-C stated when she entered R1's apartment on July 13, 2022, at around 1:00 p.m. for his initial hospice assessment, R1 was laying on his bed in a T-shirt and an incontinent product rolling back and forth in a fetal position. R1's apartment was in disarray with dirty chux pads on the floor next to his bed, old food in Styrofoam containers, and R1's mattress was soiled with wet and dried urine. R1 was responsive to RN-C and agreed he needed to go somewhere to receive more care. RN-C arranged for a non-emergent transfer to a local hospital. During an interview on August 30, 2022, at 2:07 p.m. the DHS-A stated, after R1's fall on June 19, 2022, unlicensed staff reported R1 was gagging during medication administration and drinking liquids, and was more lethargic. DHS-A stated R1's service agreement was updated on July 7, 2022, to add obtaining R1's weight every week, hourly wellness checks, and a nutritional supplement was ordered. DHS-A confirmed R1 had a decline in his condition and no RN reassessment was completed following the changes. Review of the licensee's policy and procedure	01620		

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01620	Continued From page 8 titled Initial and On-Going Nursing Assessment of Residents Under the Assisted Living License with an effective date of August 1, 2021, indicated nursing assessments are completed by a RN based upon the required assessment schedule and as needed based on the resident condition. A RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required with a change in resident's condition. Time Period for Correction: Seven (7) days.	01620		
02310 SS=G	144G.91 Subd. 4 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 standards. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide care and services according to an up-to-date service plan and based on the resident needs for one of one (R1) resident record reviewed. R1 service plan failed to address R1's preference to sleep on the floor and remove clothing and incontinent products when in bed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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	02310		

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02310	Continued From page 9 a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1's facesheet indicated R1 was admitted to the licensee on February 24, 2022, with diagnoses including a previous stroke, Parkinson's disease, and chronic obstructive pulmonary disease (COPD). R1's most current assessment dated May 25, 2022, indicated R1 required staff assistance and/or supervision with dressing, grooming, bathing, ordering incontinent products, was independent with transfers, eating, and used a walker to assist with ambulation. R1's service agreement dated June 3, 2022, indicated R1 required staff supervision to dress, groom, and one staff to assist with medication management, laundry, housekeeping, and meal preparation. R1 was independent in ambulation using a walker, transferring and eating. The service agreement failed to address R1's preference to sleep on the floor, staff interventions to ensure R1`s safety, and failed to address R1's preference to remove clothing when asleep. Review of the licensee's shift to shift "Teams" report identified R1 by his apartment number and indicated the following: 1. On February 25, 2022, at 9:51 p.m., [R1 room #] was sleeping on the floor in the living room tonight. R1 said it was more comfortable. Offered to assist with his mattress but R1 refused stating he would take care of it tomorrow. R1 preference to sleep on the floor was observed by staff the	02310		

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(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 10 night after his admission to the licensee. 2. On March 23, 2022, at 1:25 a.m., [R1 room #] sleeping on the floor at 1:00 a.m. check. 3. On May 24, 2022 at 5:26 a.m., [R1 room #] sleeping on the floor, did not want to move. 4. On July 9, 2022, at 5:07 a.m., [R1 room #] at wellness check at 4:00 a.m. R1 was asleep on the living room floor. 5. On July 9, 2022, at 12:48 p.m., [R1 room #] was on the floor laying with a pillow under his head. Asked several times if he had fallen and R1 said no several times. 6. On July 10, 2022, at 5:50 a.m., [R1 room #] was sleeping on the floor; assisted to the sofa to sleep as he requested at 11:00 a.m. 7. On July 11, 2022, at 6:02 a.m. [R1 room #] assisted from sleeping on the floor into his recliner two times. 8. On July 11, 2022, at 9:55 p.m., [R1 room #] laying on the floor a lot, he preferred to. None of the above documentation from staff internal "Teams" notes were documented in R1's progress notes. Review of R1's most recent fall assessment dated June 22, 2022, indicated R1 was at high risk for falls. A progress note date July 8, 2022, at 11:35 a.m. indicated R1 had the following falls this year: June 19, 2022, with head strike. June 3, 2022, with head strike.	02310		

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 08/23/2022

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02310	Continued From page 11 May 24, 2022, with head strike. April 25, 2022, with head strike. March 28, 2022, with head strike. March 3, 2022, with head strike. March 3, 2022, with head strike. The progress note indicated R1 was sent to the emergency room on June 30, 2022, due to not being himself and was diagnosed with two brain bleeds. During an interview on August 17, 2022, at 2:00 p.m. Unlicensed Personnel (ULP)-B stated, R1 liked laying on the floor to sleep and frequently undressed himself. R1's mattress was soiled due to R1's urinary incontinence. In addition, R1 would fall and sometimes inform staff at a later date. During an interview on August 17, 2022, at 2:00 p.m. ULP-E stated R1 preferred laying on his floor when sleeping and was capable of removing clothing shortly after staff assisted him to dress. During an interview on August 18, 2022, at 3:00 p.m. the Director of Health Services (DHS)-A confirmed the "Team" shift to shift reports were not a part of a residents' permanent medical record but were reviewed by all staff, including the Registered Nurses. During a follow up interview on August 30, 2022, at 2:07 p.m. DHS-A stated R1 preferred to sleep on the floor since his admission and preferred to sleep without clothing. DHS-A confirmed R1's preferences and staff interventions to ensure R1's safety were not added to R1's service agreement. Review of the licensee's policy and procedure titled Contents of Service Plans with an effective date of August 1, 2021, indicated all assisted	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 12 living residents have an up-to-date service plan identifying services to be provided based on the assessment by the RN. Service plans are reviewed and revised as needed based upon on-going resident assessments. Time Period for Correction: Seven (7) days.	02310		