Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL216422582M
Compliance #: HL216421756C

Date Concluded: April 29, 2024

Name, Address, and County of Licensee Investigated:
Vista Prairie 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: 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 resident was neglected when the facility failed to identify a change of condition, and provide appropriate care, services, and monitoring for a diabetic resident with a history of alcohol abuse. The resident had an unwitnessed fall with a head laceration, was transferred to the emergency department (ED), and diagnosed with a brain bleed. The resident died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident had an episode of severe hypoglycemia (low blood sugar) the week prior resulting in a fall, there was no change of condition or services, and the resident's blood sugar at the time of the incident was normal. The resident had a history of falls related to alcoholism but had been sober since 2009. Facility staff were not aware the resident was drinking prior to the incident and the residents plan of care was being implemented.

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(s), death record, hospital records, county assessments/records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident's and staff at the facility.

The resident resided in an assisted living facility with diagnoses including Diabetes Meletus type 1, neurocognitive disorder due to alcohol abuse, and bipolar II.

The resident's case management assessment completed prior to admission to the facility indicated the resident was diabetic and at risk for falls related to sudden drastic changes in blood sugar. The plan indicated the resident had a long history of alcoholism with sobriety since 2009. The plan indicated the resident utilized supportive services including family, and alcohol/drug counseling to maintain sobriety. The resident had an isolated relapse a few months prior to admission to the facility resulting in a fall, however, the resident had no current concerns for alcohol abuse at the time of admission to the facility.

The resident's admission assessment and service plan indicated the resident received wellness checks, blood sugar monitoring, and medication management services. The assessment and service plan identified the resident was at risk for falls due to low blood sugars, and indicated the resident required close monitoring. The resident had an implanted glucometer which would sound an alarm if the resident's blood sugar was low. The service plan included blood sugar monitoring 7 times daily, and wellness checks up to 8 times daily.

A progress notes the week prior to the incident indicated the resident was found unresponsive and seizing due to severely low blood sugar. The ambulance was called, and the resident was transferred to the emergency department (ED) for evaluation and treatment. The resident returned to the facility later that day with no changes.

The residents medical record and hospital after visit summary had no indication the resident was abusing alcohol at that time.

On the day of the incident, a progress note indicated staff were preparing to administer the resident's morning medications, went to check the resident's blood sugar level, and found the resident on the floor unresponsive with a gash on his head, and urgently called for help. The resident's blood sugar at the time was normal. The note indicated 911 was called, and the resident was transferred to the ED. The progress notes indicated when the family was updated about the resident's fall, they questioned at that time if the resident was abusing alcohol. The nursing staff searched the resident's apartment after the incident occurred and found 2 full, and 4 empty quart bottles of vodka hidden in paper bags covered by laundry in the resident's closet.

The residents outside medical record indicated the resident was unresponsive with a bruise to his forehead and fixed pupils bilaterally upon arrival to the ED. The resident was intubated and diagnosed with a large acute subdural hematoma (bleeding on the brain) with a midline shift. The resident's labs identified the resident had an elevated blood alcohol level on arrival to the ED. The resident was transferred to a higher level of care for emergent neurosurgery to attempt to evacuate the subdural hematoma. The record indicated the resident was transitioned to comfort care and died 9 days later.

The resident's record of death indicated the resident died as a result of a fall causing a subdural hematoma with contributing factors including Diabetes Meletus type 1, and acute and chronic alcohol use.

When interviewed several facility staff stated they never observed any evidence the resident was abusing alcohol. The staff indicated the resident was not observed to have an unsteady gate, slurred speech, or any change in mood or behavior concerning for possible intoxication or alcohol abuse.

When interviewed the resident's case manager stated the resident had been sober over a year with the exception of an isolated slip up with drinking a few months prior to his admission to the facility. The resident was actively following his sobriety plan and saw his drug and alcohol counselor regularly. The case manager stated no one suspected the resident was drinking prior to the incident, and indicated the resident was very good at hiding his addiction. The case manager stated no one could have prevented the resident from drinking especially if the resident was hiding it.

When interviewed facility leadership stated there was no indication the resident was abusing alcohol prior to the incident, and indicated the resident had no other falls at the facility. The day of the incident, when the resident received his last known wellness check, staff observed the resident laying in his bed moving around with no concerns noted. When staff entered the resident's room a few hours later the resident was found unresponsive on the floor, and staff immediately called 911.

When interviewed the resident's family member stated the facility checked on the resident and provided care and services the resident needed. The family member stated they were not aware the resident was drinking alcohol prior to the incident.

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:
The facility checked on the resident, called 911 and had the resident transferred for evaluation and treatment. The facility timely reported the incident to the Minnesota Abuse Adult Reporting Center (MAARC) and investigated the incident.

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
	21642	A. BUILDING: _____ B. WING _____	C 04/04/2024

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 On April 4, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL216422582M/#HL216421756C. No correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which 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. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	