Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL216422623M
Compliance #: HL216424459C

Date Concluded: September 27, 2022

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: 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 facility failed to assess the resident and provide interventions following multiple falls.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had numerous falls at the facility despite staff assessments, changes to the resident care plan and interventions.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's Adult Rehabilitative

Mental Health Services worker. The investigation included review of the resident's medical record, review of the resident's fall history and assessments, policies and procedures, and staff schedules.

The resident resided in an assisted living facility. The resident's diagnoses included Parkinson's disease and a previous stroke. The resident's service plan included assistance or staff supervision with dressing, grooming, bathing, medication management, incontinence care or assist to the toilet every two hours, wellness checks every two hours, housekeeping, and meal preparation. The resident was independent with ambulation with the use of a cane and/or walker and used an electric scooter for long distances in the community. The resident made his needs known to staff. The resident was capable of reporting concerns of abuse and neglect.

The facility assessment indicated the resident was a high risk for falls.

The facility incident reports indicated in the four months since the resident's admission, he had fallen seven times, hitting his head on six occasions. After each fall, facility staff determined the cause of the fall and precipitating factors that lead to the fall. With every fall, staff provided new interventions for the resident to prevent further falls.

During an interview, the nurse stated following any resident fall, the staff complete an incident report and complete a fall assessment. The resident was capable of walking independently with the use of his walker. The resident lost his balance and would fall. Staff assessed and developed interventions to protect the resident from future falls.

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 required.

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 09/02/2022

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 On September 2, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL216424459C/#HL216422623M. No correction orders are issued.	0 000		