Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL216426143M
Compliance #: HL216421565C

Date Concluded: September 27, 2023

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:
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 facility neglected the resident when they failed to provide care, services, and monitoring to identify a change in condition for a resident with malnutrition and alcohol dependency. As a result, the resident was transferred to the emergency department (ED), hospitalized, then died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident received care, services, and monitoring according to her service agreement. The resident had no change of condition prior to the resident being transferred to the ED, and facility staff transferred the resident to the ED appropriately. The resident had a sudden change of condition due to an infected pancreatic pseudo cyst which caused septic shock (a severe life-threatening infection causing organ failure) and the resident died.

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

member. The investigation included review of resident records including assessments, service agreement, progress notes, staff schedules, provider orders, medication administration records (MAR), labs, and facility policies and procedures. Also, the investigator observed other residents in the facility and interviewed family members on the facilities provision of care, services, monitoring, and communication with family.

The resident resided in an assisted living facility with diagnoses including psychosis, severe protein-calorie malnutrition, anemia, and alcohol dependence.

The resident's assessment indicated the resident was alert, oriented, and able to make her needs known. The assessment indicated the resident was independent with grooming, bathing, eating, bed mobility, transferring, ambulation, and toileting. The resident had no involuntary weight loss in the last 90 days and utilized three meals and a snack during the day, with no concerns of poor intake.

The resident's medication administration record (MAR) indicated the resident received medication administration services two times daily.

The resident's individual abuse prevention plan (IAPP) indicated the resident had a history of alcohol substance abuse. Staff were directed to report any changes in appetite, refusing to eat, change in meal and snack intake, or if the resident was more anxious. The record lacked documentation of any concerns.

A physician's order sheet indicated the provider recommended the resident abstain from alcohol.

The resident record indicated she was seen by her provider during rounds with repeat labs ordered to be rechecked about one month prior to the resident's transfer to the ED. The record lacked documentation of the labs being completed.

When interviewed the resident's provider stated when he saw the resident during rounds, he observed several open beer cans in her room. The provider stated he expressed concerns with the resident about her drinking at that time, and the resident told him it was none of his concern. The provider stated he ordered labs and reviewed a note in the resident outside medical record which indicated the resident refused the lab draw. The provider stated the resident had a sudden acute change due to an infected pancreatic pseudo cyst which caused septic shock and the resident died.

When interviewed the dietary manager (DM) stated she provided menus to the resident. The DM stated the resident rarely ate in the dining room for meals but called down and had meals brought to her room, or prepared meals for herself in her apartment. The DM stated she never observed the resident intoxicated, and indicated the resident arranged her own transportation to go shopping and returned with cases of beer in a shopping cart weekly.

Multiple staff who worked with the resident in the days leading up to the resident's hospitalization stated they did not observe any changes in the resident's condition. Staff stated the resident drank alcohol, but was never observed intoxicated, never had any falls because of her drinking, and the resident independently obtained the alcohol she consumed. Staff stated the resident either called to the kitchen for her meals, requested meals to be brought to her room, or prepared simple meals for herself. One staff stated the resident had a vague complaint of feeling a little under the weather the night before she was transferred but indicated she denied needing anything at that time. The morning the resident was transferred to the emergency department staff stated the resident rang for assistance. Staff stated when she responded the resident was having difficulty breathing, appeared afraid, and an ambulance was called. Staff stated she stayed with the resident until the ambulance left.

When interviewed the resident's family member stated she never received notification from the facility regarding the resident being transferred to the emergency department.

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:
Facility staff responded to the resident's call light, assessed the resident, called for an ambulance, then stayed with the resident until she left the facility.

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 09/11/2023

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 ******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: #HL216427707M/ #HL216424526C, and #HL216426143M/ #HL216421565C. On September 11, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 61 residents receiving services under the provider's Assisted Living license. The following order is issued for #HL216427707M/ #HL216424526C, tag identification 2360.	0 000	The Minnesota Department of Health documents the State 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 and/or Investigators ' 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 state correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys and/or complaint investigations. 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.	

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0 000	Continued From page 1	0 000	THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPY AND LEVEL ISSUED PURSUANT TO THE MINN. STAT. § 144G.31, SUBDIVISION 2 and 3.	
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: Based on interview and record review, the facility failed to ensure one of one residents (R1) were free from maltreatment. R1 was neglected. 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		