Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307033903M
Compliance #: HL307036576C

Date Concluded: September 5, 2023

Name, Address, and County of Licensee Investigated:
Vista Prairie Monarch Meadows
2135 Lor Ray Drive
North Mankato, MN 56003
Nicollet County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, 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 a resident when they failed to implement interventions and services after the resident had fallen multiple times. As a result, the resident continued to have falls and subsequent injuries.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility identified the cause of the resident's falls and communicated with medical providers to coordinate care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted case workers. The investigation included review of resident records, and employee files. Also, the investigator toured the facility and observed interactions with staff and resident.

The resident resided in an assisted living facility. The resident's diagnoses included mild intellectual disabilities, anxiety, depression, and personality disorder. The resident's service plan included assistance with medication management, dressing, bathing, housekeeping, and laundry. The resident's nursing assessment indicated the resident was independent with mobility while using a walker. The resident was able to communicate her needs but had mild developmental disabilities and memory impairments. The resident required medication to assist with managing her mood and behavior.

Facility incident reports indicated the resident fell ten times in the two-month period after her admission to the facility and all falls occurred during the evening or night hours. Within the same time frame, the resident went to the hospital six times. No serious injuries occurred from the resident's falls.

During an interview, a nurse said the resident had attention seeking behaviors. The nurse said the resident would throw herself to the ground and request to go to the hospital, but then the hospital would send her back to the facility. The nurse said she worked with the resident's medical providers and held care team meetings to discuss what interventions would assist in managing the resident's behaviors. The nurse said the fall interventions they put in place did not work because the resident's falls were intentional.

During an interview, a representative for the resident said the resident enjoyed going to the hospital. The representative said they were not aware of any unintentional falls and the resident even "faked" a seizure so she could go to the hospital. The representative said she was in communication with the facility staff and medical providers.

During consultation, the nurse practitioner said the facility communicated with medical providers regarding the resident's behaviors.

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:
(a) 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. Unable.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility coordinated medical care with physicians and case workers.

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 08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE MONARCH MEADOWS	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 August 29, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL307036576C/#HL307033903M. No correction orders are issued.	0 000		