Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302301400M
Compliance #: HL302305780C

Date Concluded: April 21, 2026

Name, Address, and County of Licensee Investigated:
Prairie View Assisted Living
1010 Elm Ave East
Hector, MN 55342
Renville County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Julie Serbus, RN
Special Investigator

Finding: Inconclusive

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 abused the resident resulting in bruises found on two of the resident's fingers on his right hand along with some redness and swelling to left wrist and the top of his left hand.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was inconclusive. Although there were unexplained bruises on two of the resident's fingers of his right hand and redness with swelling on the top of his left hand/wrist region, it could not be determined how the bruising occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member, law enforcement, and the hospice provider. The investigation included review of the resident record(s), death record, facility internal investigation, staff schedules, law enforcement report, photographs, related facility policy and procedures. Also, the investigator observed the type of hospital bed the resident used and the apartment where the bed would have been located.

Observation of the apartment including the walls next to the bed are not a smooth finish but have a textured finish.

The resident resided in an assisted living memory care unit. The residents' diagnoses included end of life hospice care and dementia. The residents' service plan included assistance with all activities of daily living including transfers, bed mobility, and feeding assistance.

The residents' assessment indicated frequent disruptive, aggressive, or socially inappropriate physical behavior towards staff during cares. The resident was not able to communicate or give accurate information consistently.

A concern arose when the facility identified unexplained injuries including bruising on the resident's right hand and left wrist.

The resident's progress note indicated the medical provider made a routine visit in the morning prior to the bruising discovered by an unlicensed caregiver. The note indicated the provider had been updated regarding the resident's recent change in condition where he had been sleeping more. The provider assessed a scabbed abrasion located on the bridge of the resident's nose but did not feel any treatment was needed. The note did not indicate any further findings at that time. The note indicated the facility licensed nurse would update hospice.

A second progress note later the same day indicated the resident remained in bed with staff turning and repositioning and providing cares. The progress note indicated bruising to the resident's fingers/wrists and that the resident slept close to the wall. The same document indicated it was unclear if the bruising was related to resident putting his hand between the wall and bed.

Later the same day, the progress notes indicated family was notified the resident may be transitioning into a more active dying stage. The family was notified of the bruising on the third and fourth fingers of the right hand and a bruised left wrist. The same progress note indicated a possible cause of the injury occurred a few days prior when the bed had been found unlevel due to the frame being unhooked and the height adjusting bar had fallen off. No further injuries were noted, and resident was unable to explain what happened due to impaired cognition.

During an interview, unlicensed caregiver #1 stated she was working the afternoon shift three days prior to staff noticing the bruising on the fingers and hands. Caregiver #1 stated she was the one who noticed the bed looked unlevel and called another staff member in from the assisted living side. The assisted living caregiver noticed the upper right side of the headboard and frame had somehow become disconnected and staff were able to put the two pieces together that evening. Caregiver #1 stated when she put the resident to bed that night did not see any skin concerns. Caregiver #1 stated it took two caregivers for cares and repositioning as the resident is not always cooperative and will push you away or swat at you. Caregiver #1

stated the left side of bed butted up against the wall and resident would lie on his side facing wall. The bed must be pulled away from the wall in order for two caregivers to complete cares.

During an interview, unlicensed caregiver #2 stated she was aware from the communication book the weekend staff reported a concern with regard to the resident's bed frame and a scratch on the nose. After that weekend, Caregiver #2 stated when giving the resident a sponge bath on Monday she noticed bruising on the right fingers and redness on left hand. Caregiver #2 stated when she picked up the resident's left hand he cried out in pain. Caregiver #2 stated she notified nursing. Caregiver stated she felt the resident's skin appeared different and thought it was part of the dying process as he was very fragile and thin.

During an interview, nurse #1 stated the resident was known for sleeping on his side next to the wall and would place his hands between the wall and the bed when sleeping. Nurse #1 stated the resident's hospital bed had been provided by hospice and set up by a durable medical provider originally.

During an interview, nurse #2 stated she was unsure of the cause of the scratch, however the resident tended to lie down in bed with his glasses on and would lay on his side facing the wall and may have bumped into the wall.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

Vulnerable Adult interviewed: No, VA was deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not appicable

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
	30230	A. BUILDING: _____ B. WING _____	C 03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VIEW	1010 EAST ELM AVENUE HECTOR, MN 55342

(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 March 16, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL302305780C/#HL302301400M. No correction orders are issued.	0 000		