Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305534563M
Compliance #: HL305537835C

Date Concluded: October 24, 2023

Name, Address, and County of Licensee Investigated:
Pleasant View Estates LLC
41 Brand Avenue
Faribault MN,
Rice 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 alleged perpetrator (AP) neglected the resident when she failed to follow the plan of care and perform safety checks. As a result, the resident fell and sustained fractures of her spine.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Staff members observed the resident two hours prior to the fall. The resident was independent in her apartment and was able to communicate her needs for assistance.

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

The resident resided in an assisted living facility. The resident's diagnoses included chronic pain, osteoarthritis, glaucoma, and macular degeneration (vision loss). The resident's service plan included assistance with dressing, grooming, bathing, laundry, housekeeping, and medication administration. Facility staff provided safety checks three times during the day and evening. The resident walked independently in her room but required a staff member to walk with her to the dining room. The resident's nursing assessment indicated she was alert, but forgetful.

The resident's fall report indicated she fell in the afternoon when was in her apartment. The resident told the AP she was getting something in her closet when she fell to the ground on her back. The resident said she crawled into her bedroom because it was softer. The resident said her back hurt and she could not move without having pain, so facility staff sent the resident to the hospital. The fall report indicated the AP saw the resident's walker in the closet door.

During an interview, the AP said the resident was totally independent in her apartment at the time of the fall. The AP said the resident was able to dress herself and only required staff to walk with her to and from the dining room because it was located on a different floor. The AP said the resident could communicate her needs and called staff when she needed assistance. The AP said the resident used her call pendant after she fell. The AP said she administered medications and another staff member provided resident cares on the afternoon when she fell. The AP said she could not remember if she saw the resident prior to her fall.

The resident's service delivery record indicated a staff member observed the resident approximately two hours prior to the fall. In addition, another staff member offered to provide toileting assistance for the resident around the same time.

The resident's progress notes indicated she was having symptoms of a bladder infection and the facility nurse received an order from the resident's physician to have the resident tested for a blader infection. The facility nurse received the physician's order only a few hours prior to the resident's fall. The notes indicated the resident received hospital care for a fracture in her back and a bladder infection. The resident returned to the facility two days later.

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: Yes.

Action taken by facility:
The facility increased the resident's services to meet her changing needs.

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
	30553	A. BUILDING: _____ B. WING _____	C 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW ESTATES LLC	41 BRAND AVENUE FARIBAULT, MN 55021

(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 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: #HL305537835C/#HL305534563M and #HL305534182C/#HL305537564M On October 2, 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 thirty-six residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL305534182C/#HL305537564M , tag identification 2360.	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 1 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	