Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202118522M
Compliance #: HL202115720C

Date Concluded: March 21, 2025

Name, Address, and County of Licensee Investigated:
Madonna Towers Living Center
4001 19th Ave NW
Rochester, MN 55901
Olmsted County

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

Evaluator's Name: Lena Gangestad, 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, who was found on the ground covered in fecal matter by family members. She was then transferred to the hospital for further evaluation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident was not receiving services from the facility.

The investigator conducted interviews with facility staff member. The investigation included review of the resident's face sheet, daily resident checklist and service agreement. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident lived in the independent building and had an agreement to rent only their apartment. The resident was not receiving services from the facility. The resident did participate

in a once a day “I’m okay” check performed via telephone by the facility receptionist, which was provided on a complimentary basis by the facility for resident’s with not services otherwise.

One Monday afternoon the resident was found on the floor in her apartment covered in fecal matter and was transferred to the hospital.

The daily resident checklist indicated the resident answered the call from the receptionist at 5:15 p.m. on both Saturday and Sunday, the weekend before the resident was found on Monday. At the time the resident was found on the floor, the time for the “I’m okay” check had not yet arrived for that day.

During an interview, a nurse stated that the resident had dementia and was not oriented to person, place, or time. The nurse stated a family member found the resident on the ground, covered in fecal matter, with an estimated time on the ground of 24-36 hours without any staff members checking on her. The nurse also stated the resident had open sores in various areas of her body, which EMS attributed to the resident dragging herself across the carpeted floor in her apartment to reach the bathroom after being unable to get up from the fall.

During an interview, a manager stated that the receptionist worked on weekends from 7 a.m. to 7 p.m. The manager stated the “I’m okay” process was the receptionist called and checked on all residents who did not have services. If a resident did not answer the phone, the receptionist either went to their apartment to check on them or notified the caregivers. The manager also stated that the resident had been experiencing hallucinations since last year, and the facility had offered the family additional services for her care, but the family declined at that time. The manager further stated if the resident needed additional services, she would not have to move to a different apartment, as the services could be added while she remained in her current apartment and there was no waiting list for assisted living or for adding more services to a resident's care plan.

During an interview, the receptionist stated that she worked on weekdays only, from 7 a.m. to 5:30 p.m. She said she typically called to check on the resident between 10 a.m. and 1:45 p.m. at most. Sometimes, the resident would call her to let her know they were okay, so she did not have to call them during the day.

During the investigation, despite making multiple attempts, the investigator was unable to reach the family members and the receptionists who worked on the weekend.

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. The resident had dementia.
Family/Responsible Party interviewed: No, attempted but did not reach.
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
	20211	A. BUILDING: _____ B. WING _____	C 03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA TOWERS OF ROCHESTER	4001 19TH AVE NW ROCHESTER, MN 55901

(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 12, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL202118522M/HL202115720C. No correction orders are issued.	0 000		