Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303876442M
Compliance #: HL303879646C

Date Concluded: February 21, 2025

Name, Address, and County of Licensee Investigated:
Speltz Estates Assisted Living
232 S Fremont St
Lewiston, MN 55952
Winona County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Deb Schillinger, RN BSN
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 abused the resident when the resident was isolated from other residents for meals.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. While the facility did briefly attempt to use mealtime as an enticement for improved personal hygiene in trying to balance the resident's right to refuse cares and the experience of other residents' mealtime experience, it was an isolated therapeutic error.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator contacted the case worker. The investigation included review of the resident record, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions during an onsite investigation.

The resident resided in an assisted living facility. The resident's diagnoses included type 2 diabetes and depression. The resident's service plan included assistance with medication management and reminders. The resident's assessment indicated the resident was independent in her decision making. The same report indicated she needed reminders but could complete her own care independently. The resident's record indicated the resident did have a history of refusing personal cares.

A concern arose the resident was being isolated in her room and fed food different from the other residents in an attempt to get the resident to be compliant with personal hygiene issues.

During an interview, an unlicensed caregiver stated they remind the resident before each meal to change soiled briefs and clothing and weekly to shower. To balance the social setting of the communal dining room, the experience of other residents, and the resident's refusal for incontinence cares, the unlicensed caregiver stated they have been instructed to discreetly give a note to the resident asking to go to the restroom and change incontinent brief and clothing. This step was taken because, while the resident has a right to refuse cares, unfortunately and other residents have refused to sit by her while they try to eat. The caregiver stated the resident has gone several weeks without bathing or showering due to refusals.

During an interview, a manager stated in addition to reminders given to the resident, the facility had tried several other interventions to encourage personal hygiene. The manager stated the lack of personal hygiene due to refusals began affecting other residents and the facility received requests from tablemates to move away from the resident. During the same interview, the manager stated the facility tries to assist with residents with transportation arrangements, but the outside transportation services began to refuse to allow the resident in their vehicles due to the issues secondary to poor personal hygiene. The manager stated reminders were given privately to the resident to encourage and remind need for personal hygiene. The facility did attempt to use mealtimes as an enticement to encourage personal hygiene, but it was determined this was ineffective and perhaps questionable, so it was quickly abandoned. The manager stated they are working with the case manager for interventions to encourage the resident to complete personal hygiene.

During an interview, a case manager stated she had met with the resident since these events occurred. The case manager stated the resident had no complaints about meals provided nor being isolated during mealtimes.

The investigator attempted to interview the resident; however, the resident declined the interview.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(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, declined
Family/Responsible Party interviewed: no family members available
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
	30387	A. BUILDING: _____ B. WING _____	C 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPELTZ ESTATES ASSISTED LIVING	232 FREMONT STREET SOUTH LEWISTON, MN 55952

(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 January 28, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL303879646C/#HL303876442M. No correction orders are issued.	0 000		