Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308359443M
Compliance #: HL308353662C

Date Concluded: April 16, 2026

Name, Address, and County of Licensee Investigated:
Valleyview of Jordan
4061 West 173rd Street
Jordan, MN 55352-8318
Scott County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, 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: The alleged perpetrator (AP) abused the resident when she hit the resident on the head with the nebulizer hose.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was inconclusive. The AP, an unlicensed caregiver, stated her actions were a way to get the resident's attention and that it was more of a tap. The resident said it hurt and became upset. No injuries were reported.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, personnel files, and staff schedules. Also, the investigator observed staff provide medications and personal care to the resident at a recent visit to the facility.

The resident resided in an assisted living facility. The resident's diagnoses included congestive heart failure, schizoaffective disorder, and mood disorder. The resident's service plan included

assistance with all medication management and partial assistance with personal care. The resident's assessment at the time of the incident indicated he was independent with mobility and could make his own decisions and verbalize his needs. The behavioral assessment included a history of angry outbursts. The resident's electronic medication administration records (EMAR) indicated inhalers and nebulizer medication were ordered to help with breathing.

A concern arose when the AP reportedly hit the resident on the top of the head with the nebulizer hose after he refused a nebulizer treatment. In response, the resident verbalized it hurt and threw his medications at the staff member and punched her in the arm.

The progress notes indicated the resident came out of his room and stated that he could not breathe so the AP gave him his inhalers. The resident said he wanted to go to the hospital. The AP took the resident's vital signs and contacted the nurse who agreed to have the resident sent to the hospital. [The progress note did not include a description of the incident under investigation].

During an interview, a nurse stated another caregiver brought forth the concern that the resident's record lacked documentation of the incident. The nurse stated because there was a delay in reporting the incident, vulnerable adult reporting was reviewed with all staff. The nurse confirmed that the resident was sent to the hospital because of breathing problems and not a result of the incident.

During interview, the administrator stated once the concern was brought to his attention, he interviewed the resident who said the AP hit him on the head after he told her he did not want the nebulizer. The administrator stated the employee said it was a "love tap" but felt it must have been more than that since the resident got upset, threw his pills at her and punched her.

During an interview, the AP stated the resident wanted to go to the hospital for difficulty breathing. The AP stated she prepared the resident's nebulizer medication and squatted down next to the resident as he was seated in his recliner. The AP stated that the resident had his head turned in the other direction, so she tapped the end of the nebulizer tube on the side of his head to get his attention to turn toward her. After she did that, the resident became upset and knocked the medications on the floor.

In conclusion, the Minnesota Department of Health determined that 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.

Vulnerable Adult interviewed: Declined the interview.
Family/Responsible Party interviewed: Unable to reach for interview.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: The facility suspended the AP during the internal investigation. The AP no longer works at the facility. The facility reviewed vulnerable adult abuse reporting with all staff.

Action taken by the Minnesota Department of Health: No 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
	30835	A. BUILDING: _____ B. WING _____	C 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEYVIEW OF JORDAN LLC	4061 WEST 173RD STREET JORDAN, MN 55352

(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 10, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL308353662C/#HL308359443M. No correction orders are issued.	0 000		