

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL203169267M
Compliance #: HL203166951C

Date Concluded: June 17, 2024

Name, Address, and County of Licensee

Investigated:

The Centennial House of Apple Valley
14625 Pennock Avenue
Apple Valley, MN 55124
Dakota County

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

Evaluator's Name: Danyell Eccleston, 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 neglected the resident when the facility failed to ensure the resident was checked hourly, given meals, and given water per her plan of care. The resident experienced falls and had an instance when she was not given food and water for twenty hours.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was inconclusive. Although there were instances when the resident did not have meals, it could not be determined if the resident was declining meals or if meals were not offered. The resident was found on the floor, however, there was conflicting accounts of how often the resident was checked and it could not be determined if neglect contributed to the residents fall(s).

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident medical

records, facility internal investigations, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff providing care to residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease and history of falls. The resident's service plan included assistance with escorts to and from meals, assistance with meals and monitoring of ability to chew and swallow liquids, re-offering food and fluids throughout shift, assist of two staff for transfers, and every two-hour repositioning.

The resident's assessment indicated the resident had weakness, multiple falls daily, experienced involuntary weight loss, and received hospice assistance. The assessment indicated a fall mat was used next to the resident's bed along with a repositioning schedule and a mechanical lift, wheelchair, and shower chair.

Review of facility internal investigation indicated the resident did not receive an evening meal and remained in her bedroom when the resident's service plan indicated she should be brought to the dining room and assisted with meals. The investigation indicated an unlicensed staff member stated the resident refused dinner but was not offered a meal or snack later. Review of video footage indicated staff checked on the resident.

During interview, a leadership member stated she received video footage from a family member regarding the resident not getting dinner. Staff members indicated the resident did not want to eat and staff did not reapproach the resident to offer food. Staff were educated to reapproach the resident after a refusal.

During interview, a nurse stated there were occasions when the resident did not receive meals and believed this was due to staff thinking the resident was sleeping. Staff were under the impression that they should not wake the resident when she was sleeping. The nurse stated the resident was often agitated and wanted to get up and move. The facility attempted interventions to prevent falls such as a Broda Chair (a wheelchair that allows for tilt positioning and seating that redistributes pressure and helps prevent skin breakdown and promotes comfort).

During interview, a family member stated the resident had a camera in her room that recorded footage with movement. The family member stated there were multiple instances recorded when a covered meal tray was left in the resident's room and the resident would not be assisted or offered the food. Another video showed a staff member asking the resident if she was hungry, but no food or beverage was brought to the resident despite the resident stating she was hungry. The family member stated there were instances when the resident experienced falls and staff working during the following shifts would not be aware of the resident's falls. Video footage was unavailable for investigator to review due to video footage storage expiring on the hosting website.

During interview, a second family member of the resident stated the resident was not checked on for many hours during family visits and there was an instance when lunch was not offered to the resident. When the second family member inquired about the lunch, staff indicated the meal was thrown away because staff thought the resident was out of the building. The family member needed to request that a nutritious meal be given to the resident.

In conclusion, the Minnesota Department of Health determined neglect 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.

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, vulnerable adult was deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility conducted internal reviews of food related incidents.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20316	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/01/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CENTENNIAL HOUSE APPLE VAL	STREET ADDRESS, CITY, STATE, ZIP CODE 14625 PENNOCK AVENUE APPLE VALLEY, MN 55124
---	---

(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	<p>Initial Comments</p> <p>On May 1, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL203166951C/#HL203169267M. No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____