Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL253022822M
Compliance #: HL253024630C

Date Concluded: July 6, 2023

Name, Address, and County of Licensee Investigated:
Valley Terrace of Owatonna
1212 West Frontage Road
Owatonna, MN 55060
Steele County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Julie Serbus, 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 when the resident signed up for hospice care without consulting his representatives.

The facility neglected the resident when the facility did not provide assistance with food or personal hygiene.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility documented resident was responsible for making his own decisions and signing documents and the facility communicated with the resident's provider frequently regarding health concerns. The facility provided services as indicated in the service plan which was updated as he declined physically. The facility provided these services as the resident allowed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family members. The investigation included review of the resident's facility record, medical provider notes, and hospice admission and provider notes. Also, the investigator toured the facility and observed staff to resident interactions.

The resident lived in an assisted living facility. The resident's diagnoses included congestive heart failure (when the heart does not pump blood sufficiently causing fluid backup), chronic obstructive pulmonary disease (inflammatory lung disease causing obstructed airflow from the lungs), diabetes with lower leg open wounds, depression, cerebrovascular accident (stroke), and anxiety. The resident's service plan indicated the resident required medication administration, showering assistance, assistance with toileting and transfers, once a week laundry, weekly light housekeeping, and used an electric scooter for mobility. The resident's nursing assessment indicated the resident was prescribed a dysphagia diet with thickened liquids but refused the diet and signed that he was aware of the risk and benefits. The same assessment indicated he was able to communicate verbally and make his needs known to staff.

The resident's progress notes indicated the resident had been refusing toileting, refusing scheduled medication, and non-compliant with controlling his diabetes resulting in poor wound healing and elevated blood sugars. Resident progress notes indicated two hospitalizations a month prior to hospice admission related to sepsis.

The Assisted Living Contract signed by the resident, listed the spouse as a designated representative but not as a power of attorney. This same contract indicated the facility did not provide routine transfers requiring two staff or a mechanical lift.

Review of Medical Provider notes indicated the resident was seen once a month if not twice a month related to health concerns. Medical provider notes indicated the resident had weeping wounds with edema to lower extremities. Medical provider discussed with resident a consultation to urology for the frequent urinary infections and endocrine for his diabetes which were both declined by the resident. Medical Provider note indicated a month prior to hospice admission indicated resident's thought processes were logical and coherent.

During investigative interviews, family members stated the resident was his own decision maker and signed his own documents. The family stated they were aware the resident would refuse medications and cares at times. The family stated prior to admission the resident was diabetic and had diabetic leg ulcers. The family members stated the resident had multiple health care issues.

During investigative interviews, multiple unlicensed staff members stated resident was able to communicate his needs. Staff stated the resident had a decline in health to include increased refusal of assistant with cares and medications. While he previously required one staff assist for

changing and cares over time her required more assistance with two or three staff members for bed mobility and cares.

During an interview, the facility nurse stated the resident had been non-compliant with cares which included toileting, using the continuous positive airway pressure (CPap) machine (machine that uses mild air pressure to keep breathing airways open while you sleep), and medications. The nurse stated the resident was noncompliant with his diabetes with elevated blood sugars and A1C (blood test that measures average blood levels over the past three months). Home care treated leg ulcers. Therapy had been attempted for strengthening but later refused by resident. Facility nurse spoke with the resident about Hospice discussing risks and benefits and with resident permission the provider was contacted, and order received for hospice evaluation. The resident stated he did not want family involved or notified related to his decision to elect hospice.

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: deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action required.

Action taken by the Minnesota Department of Health:
No further action required

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
	25302	A. BUILDING: _____ B. WING _____	C 03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY TERRACE OF OWATONNA	1212 WEST FRONTAGE ROAD OWATONNA, MN 55060

(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 29, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL253025103M/HL253028724C and #HL253022822M/HL253024630C. No correction orders are issued.	0 000		