Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL253025103M
Compliance #: HL253028724C

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 unresponsive resident when staff failed to provide cardiopulmonary resuscitation (CPR) under the direction of emergency personnel.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility does not require staff to be CPR certified and are not licensed to make the determination of the status of a resident. The staff followed their training by calling 911 and the facility on-call nurse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, case worker, and guardian. The investigation included review of resident record, facility policies pertaining emergencies, law enforcement reports, and the 911 dispatch recording. In addition, the investigator toured the facility and observe resident to staff interactions.

The resident resided in an assisted living facility The resident's diagnoses included schizophrenia, depression, and failure to thrive. The resident's service plan included code status as CPR, medication administration, and monthly vitals to include blood pressure, pulse, and respiration.

One day after the evening meal an unlicensed staff went to the resident's apartment to administer medications and found the resident unresponsive. The unlicensed staff requested assistance from another unlicensed staff member. Together staff were unable to obtain vital signs (blood pressure, pulse, or respirations). While one staff called 911 the other staff contacted the facility on-call nurse.

During an interview, the assigned unlicensed staff stated she had observed the resident return to his apartment after the evening meal. The staff stated it was time for the resident's evening medications and when she entered the resident's apartment found the resident unresponsive.

During an interview, the second unlicensed staff stated she was approached by the staff working with the resident and together went back to the resident's apartment. The resident was unresponsive with no blood pressure, pulse, or respirations. The unlicensed staff stated she called the facility on-call nurse, and the nurse provided the information the resident was listed as CPR status. The staff stated they are not required to be CPR certified, and she was not certified. She stated she remembered 911 asking if they could feel a pulse or hear breath sounds which they could not. She stated that if the 911 operator would have specifically stated for us to initiate CPR, then I would have.

During an interview, the facility nurse stated staff provided reminders for the resident and medications. The resident's medical provider came to the facility and saw the resident monthly with no recent health concerns.

During an interview, the facility administration stated CPR was not initiated as unlicensed staff were asked to determine if the resident would benefit. Staff members are not required to be CPR certified. The facility protocol when a resident is found unresponsive is to call 911, call the nurse on call if not in the building and follow instructions from 911. The facility administrator stated staff did follow facility protocol and were asked to make a decision from the dispatch call if they felt CPR should be initiated, not given direction.

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:
(a) 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. (b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes, Not Applicable, or explanatory comment

Action taken by facility:
No further action taken by the facility.

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		