

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307042843M
Compliance #: HL307044648C

Date Concluded: August 23, 2023

Name, Address, and County of Licensee

Investigated:

Madonna Meadows of Rochester
3035 Salem Meadows Drive Southwest
Rochester, MN 55902
Olmstead 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 a resident when the facility failed to provide appropriate nutrition for the resident. The resident had difficulty eating certain foods due to a past stomach surgery complications and lost a significant amount of weight while at the facility.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was inconclusive. There was conflicting information regarding the facility offering alternative foods to the resident and the resident not desiring to eat.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted an outside care agency that saw the resident during her time at the facility. The investigation included review of medical records, policy and procedures, and staff records. Also, the investigator observed staff interacting with residents and residents eating meals.

The resident resided in an assisted living facility. The resident's diagnoses included history of stomach surgery complications, lactose intolerance, and chronic acid reflux. The resident's service plan included assistance with vital signs, housekeeping and laundry, escorts and transfers, medication management, and reminders. The resident's assessment indicated the resident had mild forgetfulness and a history of hallucinations, a tendency to refuse cares, chronic weight loss, and chronic pain. The resident's assessment indicated when asked about any changes or ways the facility could best care for the resident, the resident responded, "Nothings changed, I am a picky eater." The resident's assessment also indicated she did not have difficulty chewing or swallowing, was independent with eating, and independently managed being lactose intolerant.

Review of documentation indicated the resident lost fourteen pounds in a period of five months, resulting in the resident weighing 90 pounds. Documentation indicated the resident would refuse services at times and struggled to eat food due to stomach pain, food intolerances, and dislike of foods. Documentation also indicated the resident had a preference for fruits and fruit juices and that dietician requests to the facility were not fulfilled.

During an interview, an outside of facility nurse indicated the resident was not someone who would eat much but did have items, such as sandwiches, that she liked to eat. The nurse stated she would ask the facility to provide sandwiches but was told the kitchen was closed and when meals were delivered, the resident would not receive the requested item. The nurse also stated facility staff reported the resident was eating meals, but the resident was losing weight and had wounds indicating poor nutrition.

During an interview, another outside nurse stated the resident would pick at food or food would be out of reach when the resident was in bed. The nurse stated she requested facility staff feed the resident, but facility staff stated they did not help the resident with eating meals.

During an interview, a caregiver stated the resident preferred to eat meals in her room, was particular about foods, and at times did not like the food she was given. The care giver stated if the resident needed another food item, staff would give it to her.

During an interview, a second caregiver stated the resident would often decline food and cares and wanted to stay in bed. The caregiver stated she would offer the resident alternative food items, but the resident would refuse the offer.

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, resident deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

No action taken.

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: 30704	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/12/2023
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NAME OF PROVIDER OR SUPPLIER MADONNA MEADOWS OF ROCHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3035 SALEM MEADOWS DR SW ROCHESTER, MN 55902
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(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>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>#HL307047067M/ #HL307043452C #HL307042843M/ #HL307044648C</p> <p>On July 12, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 60 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for #HL307047067M/ #HL307043452C, tag identification 2360.</p>	0 000		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.</p>	02360		

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

Minnesota Department of Health

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02360	<p>Continued From page 1</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility.</p> <p>Please refer to the public maltreatment report for details.</p>	02360		