*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL253021702M
**Compliance #:** HL253022709C

**Date Concluded:** May 13, 2025

**Name, Address, and County of Licensee Investigated:**
Valley Terrace of Owatonna
1212 W Frontage Rd
Owatonna, MN 55060
Steele County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Lena Gangestad, 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, who burned herself while smoking, after falling asleep with a lit cigarette in her hand.

**Investigative Findings and Conclusion:** The Minnesota Department of Health determined neglect was not substantiated. While it was true the resident burned her fingers while smoking, the facility had offered options such as smoking cessation and/or other safety measure, but the resident declined these interventions.

The investigator conducted interviews with facility administrative staff, and the resident. The investigation included review of the resident's records, incident reports, policies, and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included type 2 diabetes, neuropathy, and tobacco dependence. The resident's service plan included needs

assistance with medication management and transferring as needed. The resident used an electric wheelchair independently and

A concern arose the resident burned her fingers on her right hand due to smoking.

The progress notes indicated she burned her fingers while smoking after falling asleep with a lit cigarette in her hand.

The resident's medical provider notes indicated the resident smoked two packs of cigarettes a day and had recently started used her left hand to smoke. During multiple visits, the physician discussed smoking cessation with the resident, but she continued to decline quitting.

During an interview, the resident stated she had neuropathy and could no longer feel her fingers. She said that she had been smoking, fell asleep, and the cigarette burned her fingers. She also said the staff had encouraged her to quit smoking, but it was difficult. She had tried using the nicotine patch, but it had not worked for her. She added she was well cared for by the staff and had no concerns.

During an interview, a manager, who was also a nurse, stated the resident had previously been deemed unsafe to smoke due to a history of burning her fingers. The facility suggested the resident wear gloves while smoking but she would not do so. The manager also stated the facility offered smoking cessation programs, but the resident was unwilling to quit smoking. The resident was free to come and go as she chose and smoked outside where supervision what not available.

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**: Yes.
**Family/Responsible Party interviewed**: No.

**Alleged Perpetrator interviewed**: Not Applicable.

**Action taken by facility:** No action required.

**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

| 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 04/28/2025 |

| 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<br><br>On April 28, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL253021702M/HL253022709C. No correction orders are issued. | 0 000 | | |