Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL211293722M
Compliance #: HL211297207C

Date Concluded: August 28, 2025

Name, Address, and County of Licensee Investigated:
Abilit Holdings Meadow Lakes
22 45th Avenue NW
Rochester, MN 55901
Olmsted County

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

Evaluator's Name: Brooke Anderson, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 staff failed to complete safety checks or investigate the door alarm resulting in the resident eloping, falling, and being hospitalized.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident's assessment indicated the resident was not an elopement risk; however, progress notes indicated the resident had increased confusion and needed memory care support. Facility staff failed to complete safety checks, did not investigate the door alarm and the resident left the assisted living without staff's knowledge. Police found the resident on the side of the road; he was transferred to the hospital and subsequently moved to a memory care unit.

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

hospital records, facility internal investigation, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included Parkinson's disease and neurocognitive disorder with Lewy bodies. The resident's service plan included assistance with safety checks, medication management, and oxygen management. The service plan indicated the resident did not have a vulnerability to elopements. The resident's assessment indicated the resident had moderate cognitive impairment with a history of disorientation and required supervision and oversight for safety.

Documentation approximately two weeks before the incident, indicated staff found the resident's personal belongings in the hall. The resident stated he had to leave. The resident was sent to the emergency room for altered mental status. During the hospitalization, the resident required one on one supervision. Facility management had conversations with a family member that the resident should move to a memory care unit.

Facility investigation documentation indicated the night of the incident the resident was sitting in the facility dining room at a table. The resident was seen getting up, looking out the windows and walking out the door in the dining room. Facility staff #1 was seen getting up, shutting the alarm off, and sitting back down. Facility staff #2 was not seen responding to the door alarm.

Police reports indicated the resident was found lying on the shoulder of the road. He was confused and could not tell the officer where he lived. The resident had a cut on his left elbow and was transported to the hospital.

Hospital records indicated the resident was not a reliable historian and had previous emergency room visits with increased confusion, disorientation and hallucinations. The resident was found wearing a t-shirt, depends (incontinent brief), socks, and shoes. He was unable to tell the police what his birth date was. The resident stated he banged himself up on his left elbow on the pavement and had abrasions to his left knee, left arm, and right knuckles. The police attempted to contact the facility but was unable to reach staff.

During an interview, facility staff #1 stated safety checks for the resident were supposed to be every two hours and because of poor communication with coworkers, the safety checks were not completed. When the alarm went off, he assumed it was another resident that would go out and smoke around that time. Facility staff #1 stated he called facility staff #2 who stated it was probably another resident.

During an interview, facility staff #2 stated the resident was showing signs of increased confusion and facility management was aware of it. He was new to the facility when the incident occurred. He was not formally trained to ensure the doors were locked. Facility staff #2 stated the alert system wasn't on all the tablets so when the alarm went off, facility staff #1 was

the only one that heard it. Facility staff #2 stated facility staff #1 did not call about the alarm that night and he was not aware the resident eloped until police arrived at the facility.

During an interview, facility management stated the resident had a decline in condition in the months prior to the incident. He had a change in behaviors, hallucinations, and had an erratic sleep schedule. The resident had multiple incidents of being found in the hallway of the facility confused. Facility management stated every one-hour checks were implemented for the resident.

During an interview, a family member stated in the weeks prior to the incident, the resident's cognition declined and he was sundowning (a state of confusion that occurs in the late afternoon and lasts into the night.) He was not aware of any interventions the facility had in place to keep the resident safe. A family member stated after the incident facility management was helpful with finding memory care placement for the resident.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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 no longer resided at the facility.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility conducted an internal investigation and provided elopement education to staff.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Olmsted County Attorney
Rochester City Attorney
Rochester Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21129	A. BUILDING: _____ B. WING _____	C 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (MEADOW LAKES)	22 45TH AVENUE NW ROCHESTER, MN 55901

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. INITIAL COMMENTS: #HL211297207C/#HL211293722M On August 20, 2025, 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 68 residents receiving services under the provider ' s Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL211297207C/#HL211293722M , tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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02360	Continued From page 1	02360		
02360	144G.91 Subd. 8 Freedom from maltreatment 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. 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. Findings include: 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. Please refer to the public maltreatment report for details.	02360		