Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL247806061M
Compliance #: HL247808703C

Date Concluded: January 21, 2025

Name, Address, and County of Licensee Investigated:
Amazing Love Assisted Living
5724 Bass Lake Road
Crystal, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela RN
Special Investigator

Carrie Euerle MPH, MSN, 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 facility staff failed to provide adequate supervision, resulting in multiple elopements from the facility. In addition, staff failed to ensure adequate supervision resulting in the resident being sexually assaulted by another resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident admitted to the facility with a history of elopement and eloped approximately fifteen times within a five-month period. Nursing staff failed to assess the resident following the elopements and failed to implement interventions to

protect the resident's health and safety following each elopement. It was unable to be determined if a sexual assault occurred. Law enforcement records related to the incident indicated there was not enough evidence available to substantiate sexual assault occurred and the resident later reported she had consensual sex with the other resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement and the resident's case manager. The investigation included review of resident records, facility documentation, personnel files, staff schedules, law enforcement reports, and related facility policies and procedures. At the time of the onsite investigation, the investigator observed the facility, staff interactions, mealtime procedures, and facility activities.

The resident resided in an assisted living facility with a diagnosis of schizophrenia. The resident admitted to the facility with a history of elopement and medication non-compliance, required behavior and mental health management, including monitoring for self-injurious behaviors. The resident's service plan included assistance with activities of daily living, medication management, behavior monitoring, housekeeping, and laundry. The resident's care plan identified for staff to complete daily and hourly rounds on the resident and update the resident's medical provider if the resident left the facility.

Facility documentation and the resident's medical record included approximately fifteen elopements over a five-month period. Facility staff did not consistently document the length and/or time(s) of the elopements, behavior prior to the elopements, when the resident was discovered missing or left the facility, actions immediately taken following the discovery of the elopement, follow-up documentation, and/or actions taken to mitigate further incidents. The resident was not assessed by nursing staff upon return to the facility and no additional interventions were implemented to protect the resident's health and safety following the elopements.

In addition, the resident's medical record lacked evidence of the medical provider being updated regarding the multiple and frequent elopements and missed medication doses due to the resident's absence.

The elopements were reported to law enforcement and a review of law enforcement records confirmed law enforcement's response to the facility. Law enforcement records also included contact with the facility related to concerns with the resident's frequent elopements, lack of supervision provided by the facility, failure of staff to follow facility policies and procedures, falsified documentation, quality of care, and the use of community and emergency resources.

During interview, the resident stated that she wanted to be more independent and that she should be able to go out into the community independently.

During an interview with law enforcement, they indicated there was a high volume of calls and responses to the facility and that they met with the facility regarding the ongoing elopements and quality of care concerns.

During interview, facility management acknowledged the resident's frequent elopements and meetings with law enforcement to discuss concerns.

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

Action taken by facility:
None.

Action taken by the Minnesota Department of Health:
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
The Minnesota Board of Nursing
The Minnesota Board of Executives for Long Term Services and Supports
City of Crystal Attorney
Hennepin County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24780	A. BUILDING: _____ B. WING _____	C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING LOVE ASSISTED LIVING	5724 BASS LAKE ROAD CRYSTAL, MN 55429

(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: #HL247806520C #HL247808703C/#HL247806061M On October 9, 2024 through October 25, 2024,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 14 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL247806520C, tag identification 1600 and #HL247808703C/#HL247806061M, tag identification 2310, 2360.	0 000	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.	
01600 SS=G	144G.70 Subdivision 1 Acceptance of residents An assisted living facility may not accept a person as a resident unless the facility has staff, sufficient in qualifications, competency, and	01600		

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01600	Continued From page 1 numbers, to adequately provide the services agreed to in the assisted living contract. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to ensure staff had the sufficient qualifications, competency, and numbers to adequately provide the services agreed to in the assisted living contract prior to admission of one of one resident (R1) who had a history of mental health disorders, elopements, and a history of substance abuse. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1 admitted to the facility with a history of elopements, medication non-compliance, and mental health diagnoses and behaviors that required monitoring, medication management, behavior and mental health management, and monitoring for self-injurous behaviors. R1's medical record identified these areas; however, licensee staff did not implement identified interventions, follow R1's careplan or mental health management plan, address behaviors, or implement interventions to protect R1's safety following mulitiple elopements from the facility. R1's medical record indicated R1 admitted to the	01600		

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01600	Continued From page 2 licensee on March 19, 2019, with the diagnoses of schizophrenia. R1's care plan dated March 1, 2024, indicated R1 was under civil commitment (court ordered institutionalization). R1's care plan indicated staff were to provide medication management, medication administration, mental health management, dressing, bathing, and grooming assistance, and housekeeping. R1's care plan included under mental health management identified monitoring R1 for self-injurious behaviors, monitor for hallucinations, history of leaving the licensee and not returning for more than two-days for which staff would follow the licensee's missing person policy. The staff should notify R1's provider if R1 leaves for more than two-days for a medication review, including R1's order for Clozaril (mental health medication). Staff encouraged R1 to sign-out, encourage R1 to wear a Belle Pendent, (used to call 911), Staff to complete daily rounds every one to two hours, monitor how much time is spent on the licensee's phone, monitor 911 calls, monitor for substance abuse including cocaine, methamphetamines and cannabis. Monitor R1 for dangerous behaviors to obtain substances. Monitor R1 for paranoia for which R1 prefers one-to-one visits. Staff to ask R1 for an as needed, (PRN), medication to alleviate hallucinations. R1's behavior plan dated April 23, 2024, (unsigned), indicated R1 had a history of the following behaviors: verbal abuse, agitation, repetitive behaviors, going into other's rooms, anxiety, confrontational, hallucinations, property destruction, multiple 911 calls, threatens staff, threatens other residents, pacing, self-neglect, elopements and drug abuse. Interventions included: redirections, staff one-to-one, fifteen	01600		

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01600	Continued From page 3 minute to two-hour safety checks for anxiety, quiet space, complete a missing person report and call 911 if R1 elopes. A July 15, 2024, civil commitment document for R1 indicated R1 had not followed her provisional discharge plan, including leaving the licensee on a few occasions without notifying staff, thus missing oral medications or being late on her scheduled long-acting injections and has admitted to using drugs provided to her. The commitment documented indicated R1 had a history of substance abuse and suicidal ideation. R1 was receiving individual home supports, (IHS), with nine hours of training weekly while the IHS supports assist with shopping, activities, and training on personal skills. R1 had a psychiatric provider and orders for Clozaril, Prolixin, and a long acting injectable, (LAI), form of Prolixin. R1 had a JARVIS, (an order that allows a medical professional to request a resident receive psychiatric medications against their will) order despite agreeing to be compliant with medications. The document indicated R1 was to remain under civil commitment at this time. A nursing re-assessment completed on July 24, 2024, indicated R1 frequently left the facility and does not return. The assessment indicated staff met with R1 to discuss when leaving the licensee, to call staff to check-in on R1's whereabouts and consistency with taking prescribed medications if out for extended periods, all to which R1 agreed to understanding. The assessment indicated the licensee made frequent calls to law enforcement (LE) to file missing person reports and indicated R1 was to call staff if she would be out more than a twenty-four hours. R1's service plan dated July 24, 2024, indicated	01600		

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01600	Continued From page 4 R1 received daily assistance with dressing, grooming, toileting, stand by assist (SBA) with mobility, medication management, behavior monitoring, housekeeping, and laundry. R1's individual abuse prevention plan, (IAPP), dated September 1, 2024, indicated R1 was an elopement risk and at risk for sexual abuse. The IAPP indicated R1's mental health and independent decision-making placed R1 in vulnerable situations when leaving the licensee. R1's risk factors included the following: diagnoses of schizoaffective disorder leads to disorganized thinking, mood instability and delusions. R1 had a tendency to elope, substance use disorder, specifically when R1 leaves the licensee. Interventions included: discuss boundaries with R1, encourage R1 to leave the licensee with staff or IHS worker. Staff encouragement of continued education to R1 regarding safety when not in the licensee, including provided communication devices, even though R1 expressed that she does not want her whereabouts known and preferred not to be contacted. Staff would work with R1's psychiatrist to ensure medication for schizoaffective disorder are monitored, reviewed and adjusted PRN to assist in mood stability, delusion reductions, decreased disorganized thoughts and vulnerability. Encourage R1 to attend regular mental health check-ins to assess effectiveness of the treatment plan. Staff would monitor, remove R1 from an incident, report, assess and offer medical evaluation for any signs of abuse. A review of R1's progress notes indicated R1 eloped from the facility on the following dates: -May 4, 2024 -May 15, 2024 -May 23, 2024	01600		

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01600	Continued From page 5 -May 26, 2024 -May 31, 2024 -June 1, 2024 -June 3, 2024 -July 17, 2024 -August 2, 2024 -August 9, 2024 -August 13, 2024 -August 17, 2024 -August 26, 2024 -September 5, 2024 -September 10, 2024 R1's IAPP was not updated to include each elopement and the IAPP interventions were not followed by licensee staff. No additional assessment of R1 was completed following the multiple elopements and no additional supervision was implemented to ensure R1's safety. R1's medical record did not include consistent or detailed information of R1's elopements including the last time R1 was seen at the facility, how long R1 was missing, when R1 returned to the facility, who was contacted regarding the elopement or return of R1, or action taken to search for R1. Upon R1's returns to the facility, there was no indication of an assessment completed of R1 or additional interventions or supervision implemented to ensure R1's safety. R1's medical record lacked documentation to indicate staff implemented mental health interventions identified on R1's care plan and behavior monitoring plan and following multiple elopements and law enforcement interactions, R1's care plan and/or behavior monitoring plans were not re-evaluated or updated to reflect R1's current status or more effective interventions or	01600		

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01600	Continued From page 6 approaches. A review of law enforcement records included an undated law enforcement letter sent to the facility, indicated a caution to all parties concerning R1, that when R1 was reported a missing person, licensee services could not have been provided as R1 was not in the licensee and indicated the licensee could not bill for services. A law enforcement, (LE), report dated July 19, 2024, at 10:15 a.m., indicted that a LE officer and law enforcement mental health coordinator, (LE)-F, responded to the licensee regarding R1's July 17, 2024 elopement. Licensee staff informed LE that R1 did not sign out, they did not know R1's whereabouts, informed that R1 would often check herself into an area hospital. This report indicated LE-F checked with the area hospital and R1 was not admitted there. This report indicated R1's elopements were a reoccurring concern, R1 leaves for a few days at a time, and had a history of using illicit substances, the licensee had not made any efforts to locate R1. LE was informed by the licensee that a missing person's policy was being reviewed by licensee administrative staff and not yet being utilized and LE would be reporting the incident(s) as a vulnerable adult neglect concern. Law enforcement records also included a report dated July 28, 2024, at 1:00 p.m., which indicated the licensee called to report R1 missing. LE informed the licensee of the ongoing issue of R1 leaving the facility, staff not knowing or showing concern for R1's safety or misuse of emergency resources when R1 had repeated been reported as a missing person when R1 had left the licensee.	01600		

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01600	Continued From page 7 During an interview dated October 23, 2024, at 11:03 a.m., a law enforcement officer (LE)-F stated R1 has been involved in a high volume of LE calls and responses. LE-F stated R1 has had thirty-seven missing persons cased from the year 2019 to present. LE-F stated R1 is not transparent where she is going and the licensee policy is to use the sign-in/sign-out sheet. LE-F stated when R1 leaves the licensee, the licensee calls to report a missing person, R1 returns a couple of days later then R1 is taken out of LE's missing persons system. LE-F stated the licensee does not follow the licensee's missing person protocol. LE-F stated that on July 26, 2024, the licensee falsified an incident report regarding R1's elopement. LE-F stated the licensee documented following missing person's protocol but actually do not follow their own policy. LE-F recalled at one time, another city's LE found R1 and called their LE agency. LE-F stated when the licensee was informed R1 was in another city, the licensee stated that they would not pick-up R1 so LE had to return R1 back to the licensee. LE cannot bill for the transportation of R1 back to the licensee. The licensee had met with LE regarding the multiple elopements and quality of R1's care concerns. During an interview on October 25, 2024 at 1:34 p.m., the licensed assisted living director (LALD) acknowledged R1 had multiple elopments from the facility and that law enforcement had been contacted multiple times and had met with facility administration regarding concerns over R1 and R1's frequent elopements. No further information provided. Time Period for Correction: Seven (7) Days.	01600		

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02310	Continued From page 8	02310		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure appropriate care and services were provided based on the resident's needs in accordance with an up-to-date service plan and accepted health care standards for one of one resident (R1) with a known history of elopement. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's medical record indicated R1 admitted to the licensee on March 19, 2019, with a diagnosis of schizophrenia. R1's care plan dated March 1, 2024, indicated R1 was under civil commitment (court ordered institutionalization) at the facility. R1's care plan indicated staff were to provide medication	02310		

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02310	Continued From page 9 management, medication administration, mental health management, dressing, bathing, grooming assistance, and housekeeping. R1's care plan included mental health management and identified monitoring R1 for self-injurious behaviors, monitoring for hallucinations, history of leaving the licensee and not returning for more than two-days and directed for staff to follow the licensee's missing person policy. Staff should notify R1's provider if R1 leaves for more than two-days for a medication review, including R1's order for Clozaril (mental health medication). Staff were to encouraged R1 to sign-out, encourage R1 to wear a Belle Pendent, (used to call 911), Staff to complete daily rounds every one to two hours, monitor how much time is spent on the licensee's phone, monitor 911 calls, monitor for substance abuse including cocaine, methamphetamines and cannabis. Monitor R1 for dangerous behaviors to obtain substances. Monitor R1 for paranoia for which R1 prefers one-to-one visits. Staff to ask R1 about as needed, (PRN), medication to alleviate hallucinations. R1's behavior plan dated April 23, 2024, indicated R1 had a history of the following behaviors: verbal abuse, agitation, repetitive behaviors, going into other's rooms, anxiety, confrontational, hallucinations, property destruction, multiple 911 calls, threatens staff, threatens other residents, pacing, self-neglect, elopements and drug abuse. Interventions included: redirections, staff one-to-one, fifteen minute to two-hour safety checks for anxiety, quiet space, complete a missing person report and call 911 if R1 elopes. A review of R1's progress notes indicated R1 eloped from the facility on the following dates:	02310		

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02310	Continued From page 10 -May 4, 2024 -May 15, 2024 -May 23, 2024 -May 26, 2024 -May 31, 2024 -June 1, 2024 -June 3, 2024 R1's medical record did not indicate that staff contacted R1's provider regarding R1's missed medications following each elopement as indicated in R1's careplan. R1's record included no documentation of staff monitoring R1 for self-injurous behaviors, substance use, or elopements, and included no indication of staff following R1's behavior plan including completing 1:1 visits, or additional safety checks. R1's care plan was not updated following the multiple elopements in May and June 2024. R1's IAPP was not updated following the May and June 2024 elopements. No additional assessment of R1 was completed following the multiple elopements and no additional supervision was implemented to ensure R1's safety. A nursing re-assessment completed on July 24, 2024, indicated R1 frequently left the facility and did not return. The assessment indicated staff met with R1 to discuss when leaving the licensee, to call staff to check-in on R1's whereabouts and consistency taking prescribed medications if out for extended periods, all to which R1 agreed to understanding. The assessment indicated the licensee made frequent calls to law enforcement (LE) to file missing person reports and indicated R1 was to call staff if she would be out more than a twenty-four hours.	02310		

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02310	Continued From page 11 R1's service plan dated July 24, 2024, indicated R1 received daily assistance with dressing, grooming, toileting, stand by assist (SBA) with mobility, medication management, behavior monitoring, housekeeping, and laundry. R1's medical record indicated R1 continued to have multiple elopements from July through September 2024. R1's progress notes indicated the following elopements: -July 17, 2024 -August 2, 2024 -August 9, 2024 -August 13, 2024 -August 17, 2024 -August 26, 2024 -September 5, 2024 -September 10, 2024 Further review of R1's medical record and service delivery records indicated staff documented services provided inconsistently and documented services provided during the duration of some of the elopements, despite documenting in progress notes that R1 was not at the facility and documenting that medications were not administered due to R1 not being in the facility. R1's medical record did not indicate that staff contacted R1's provider regarding R1's missed medications following each elopements as indicated in R1's care plan. R1's record included no documentation of staff monitoring R1 for self-injurious behaviors, substance use, or elopements and included no indication of staff following R1's behavior plan, completing 1:1 visits, or additional safety checks. R1's care plan was not updated following the multiple elopements in July, August, and September 2024.	02310		

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02310	Continued From page 12 R1's individual abuse prevention plan, (IAPP), dated September 1, 2024, indicated R1 was an elopement risk and at risk for sexual abuse. The IAPP indicated R1's mental health and independent decision-making placed R1 in vulnerable situations when leaving the licensee. R1's risk factors included the following: diagnoses of schizoaffective disorder leads to disorganized thinking, mood instability and delusions. R1 had a tendency to elope, substance use disorder, specifically when R1 leaves the licensee. Interventions included: discuss boundaries with R1, encourage R1 to leave the licensee with staff or IHS worker. Staff encouragement of continued education to R1 regarding safety when not in the licensee, including provided communication devices, even though R1 expressed that she does not want her whereabouts known and preferred not to be contacted. Staff would work with R1's psychiatrist to ensure medication for schizoaffective disorder are monitored, reviewed and adjusted PRN to assist in mood stability, delusion reductions, decreased disorganized thoughts and vulnerability. Encourage R1 to attend regular mental health check-ins to assess effectiveness of the treatment plan. Staff would monitor, remove R1 from an incident, report, assess and offer medical evaluation for any signs of abuse. R1's IAPP was not updated to include each elopement and the IAPP interventions were not followed by licensee staff. No additional assessment of R1 was completed following the multiple elopements and no additional supervision was implemented to ensure R1's safety. R1's medical record did not include consistent or detailed information of R1's elopements including	02310		

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02310	Continued From page 13 the last time R1 was seen at the facility, how long R1 was missing or length and time of each elopmen, when R1 returned to the facility, if anyone was contacted regarding the elopement or return of R1, or action taken to search for R1. Upon R1's returns to the facility, there was no indication of an assessment completed of R1 or additional interventions or supervision implemented to ensure R1's safety. R1's progress note dated September 5, 2024 2:05 p.m. indicated staff held a collaborative meeting with the law enforcement mental health coordinator, (LE)-F and R1's mental health case manager (CM)-D. R1 refused to attend. The note indicated changes suggested during the meeting regarding the licensee's sign-out sheets would be implemented. A review of law enforcement records included an undated law enforcement letter sent to the facility, indicated a caution to all parties concerning R1, that when R1 was reported a missing person, licensee services could not have been provided as R1 was not in the building at the time and indicated the licensee could not bill for services. Law enforcement records also included a report dated July 28, 2024, at 1:00 p.m., which indicated the licensee called to report R1 missing. LE informed the licensee of the ongoing issue of R1 leaving the facility, staff not knowing or showing concern for R1's safety or misuse of emergency resources when R1 had repeatedly been reported as a missing person when R1 had left the licensee. A law enforcement report dated August 15, 2024, at 9:28 a.m., indicated the licensee called LE and when LE attempted to speak with licensee's staff	02310		

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02310	Continued From page 14 regarding R1's elopement, the staff called another staff member but LE was unable to hear the name of the staff called. LE gave staff LE's work cell number and requested the staff to call LE directly. There was no return call to LE, LE attempted to call the licensee twice and there was no answer. A law enforcement report dated August 15, 2024, at 1:25 p.m., indicated LE was contacted regarding R1. LE was informed that R1 left on August 13, 2024 at 4:51 p.m. Licensee staff informed LE that they had attempted to call area hospitals and completed a community search without success in finding R1. Staff informed LE that R1 did not sign-out and reviewed the licensee's cameras. Staff informed LE that R1 was free to come and go as she wished. LE informed the licensee that since year 2019, R1 had eloped thirty-one times and LE was dispatched. LE inquired with staff on how someone on a civil commitment is allowed to come and go freely. LE reminded staff regarding the incident on August 10, 2024, in which, staff refused to pick-up R1 after being located in another city. The report indicated LE attempted to call R1's case manager twice, (CM)-D, but only received her voice mail and a message was left by LE to return a call. A law enforcement report dated August 27, 2024, at 9:15 p.m., indicated LE received a call that R1 left the licensee and had not returned. The report indicated R1 left the licensee on August 26, 2024, at 3:00 p.m. and had not returned. Staff informed LE that licensee protocol was followed included driving around looking for R1 August 27, 2024, but the search excluded a location R1 frequented. Staff informed LE that he did not have a clothing description, access to the licensee's cameras,	02310		

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02310	Continued From page 15 and R1 had a sign-out entry that indicated 3:00 p.m. no signature, no date, no information. A law enforcement report dated September 9, 2024, indicated LE completed a missing person report and included that R1 frequently eloped from the licensee, had a mental health diagnoses, was a known drug user and court ordered to be at the licensee. A law enforcement (LE) report provided to the MDH investigator via email on October 23, 2024 at 11:38 a.m., indicated there was a minimum of twenty days between March 12, 2024 and July 31, 2024, services could not have been provided as R1 was not in the licensee receiving services due to being a missing person, therefore services could not be billed. During an interview dated October 23, 2024, at 11:03 a.m., a law enforcement officer (LE)-F stated R1 has been involved in a high volume of LE calls and responses. LE-F stated R1 has had thirty-seven missing persons cased from the year 2019 to present. LE-F stated R1 is not transparent where she is going and the licensee policy is to use the sign-in/sign-out sheet. LE-F stated when R1 leaves the licensee, the licensee calls to report a missing person, R1 returns a couple of days later then R1 is taken out of LE's missing persons system. LE-F stated the licensee does not follow the licensee's missing person protocol. LE-F stated that on July 26, 2024, the licensee falsified an incident report regarding R1's elopement. LE-F stated the licensee documented following missing person's protocol but actually do not follow their own policy. LE-F recalled at one time, another city's LE found R1 and called their LE agency. LE-F stated when the licensee was informed R1 was in another city, the	02310		

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02310	Continued From page 16 licensee stated that they would not pick-up R1 so LE had to return R1 back to the licensee. LE cannot bill for the transportation of R1 back to the licensee. The licensee had met with LE regarding the multiple elopements and quality of R1's care concerns. During an interview on October 24, 2024, at 1:08 p.m., R1 stated she desired to be more independent and is working on getting a case manager that is closer to her location. R1 stated she is looking to get a job. R1 stated is should not be an issue if she goes into the community independently. It is not of the licensee's business. R1 stated when she did leave the licensee, she did tell them where she went. R1 stated she alerts people that should know but knows "they" are leaking it to the cops, including the "thief catching department" that is currently investigating my whereabouts. R1 stated she never leaves the licensee unless she is going to people's houses to sleep at night. R1 stated she usually goes to a church that is open between 8:00 a.m. and 4:30 p.m. or the malls. R1 stated she had a bus card for transportation provided by CM-D. During an interview dated October 21, 2024, at 1:02 p.m., R1's case manager (CM)-D stated R1 agreed to follow the licensee's rules, including utilization of the licensee's sign-out/sign-in form. CM-D stated being aware that R1's signing-out when leaving had not improved. CM-D stated R1 was provided a cellular phone but had lost it or traded it for drugs. CM-D stated R1 would freely admit when using substances. CM-D was currently seeking a more independent setting for R1 even though that type of setting has not gone well for R1.	02310		

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02310	Continued From page 17 During an interview dated October 25, 2024, at 1:34 p.m., Licensed assisted living director, (LALD)-A, stated R1 was good at coming and going out of the building. R1 may have come back and left the facility again during some of the dates of documented elopements, however, LALD-A did not have the documents in front of her to refer to and would have to review them later. The MDH investigator inquired why the licensee's sign-out sheets dated July 2024 to September 2024, were not received via the investigator's Minnesota Department of Health (MDH), email address, LALD-A stated the licensee may not have been using the sign-out sheets as regularly for those months, but LALD-A would check on it. No further information was provided. Time Period for Correction: Seven (7) Days	02310		
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	02360		

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02360	Continued From page 18 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		