

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL257298123M
Compliance #: HL257294402C

Date Concluded: April 11, 2025

Name, Address, and County of Licensee

Investigated:

Select Senior Living
11350 Martin Street NW
Coon Rapids, MN 55433
Anoka County

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

Evaluator's Name: Christine Bluhm, 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: The facility neglected the resident when it did not verify his whereabouts while performing safety checks. The resident was not in his room but had left the building, not dressed for the cold weather, and found deceased outside in the neighborhood.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident was observed with increased confusion and later during overnight safety checks was not found in his room. The facility did not initiate a search for the missing resident and remained unaware of his whereabouts until the next morning when police contacted the facility. The resident had been found deceased outside in the neighborhood.

The investigator conducted interviews with facility staff members, including nursing and unlicensed staff. The investigator contacted law enforcement and the case worker. The investigation included review of the resident record, death record, clinical records, facility internal investigation, facility incident reports, staff schedules, law enforcement report, and

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related facility policy and procedures. Also, the investigator observed resident activity and staff interactions with residents at the facility as well as the location and functions of the exit doors.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes, lung and heart disease. His vulnerability assessment indicated he was legally blind, had an unsteady gait and used a cane for assistance. The cognitive assessment indicated the resident was alert and oriented with poor decision making and safety awareness but able to understand directions. The resident was given reminders to sign out if he planned to leave the facility.

The resident's service delivery record indicated the resident had scheduled toileting reminders, vulnerability, behavior and safety checks at 10:30 p.m., 11:00 p.m., 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. The service checkoff record indicated safety checks were scheduled to see that the resident was safe or needed assistance with toileting or getting a drink. Under the section titled behavior management, it indicated the resident at times did not sign out when he left the facility, and frequently went for walks to a relative's house typically every Sunday for a few hours to visit.

An incident report dated several months prior to the resident's death, indicated police were called to assist to locate the resident when staff thought he wandered out of the building and could not be located. The same document indicated concerns were raised if the resident could safely go out into the community alone and that he did not sign out before leaving the facility. After investigating the incident, the facility noted that family said the resident had always gone for walks in the afternoon and evening and often visited a niece who lived in the neighborhood. The resident was encouraged to sign out when leaving the building after the incident.

The elopement risk evaluation assessment indicated the resident did not wander and was not an elopement risk.

The progress notes indicated the resident had two falls within ten days prior to the incident. The same documents indicated a cat had been found living in the resident's apartment and his family was contacted due to the facility was pet free.

One December evening, facility staff observed the resident walking around confused, carrying a cat and at one point trying to go outside not dressed for the cold weather. The resident's behavior was not reported or communicated as concerning. Later that night, facility staff observed the resident was not in his room during safety checks. The sign out log was checked to see if he logged himself out of the facility, but he had not. The facility remained unaware of the residents whereabouts the police contacted the facility at 6:00 a.m. the following morning saying the resident had been found dead in the neighborhood.

The facility internal investigation record indicated the evening caregiver observed the resident was in the hallway carrying a cat and said he was waiting for his brother to arrive to get the cat. The document indicated the caregiver said he seemed confused and appeared to be heading

outside. The same document indicated the night staff caregiver did not receive any concerning report from evening staff and did the overnight round but did not find the resident in his room nor had the resident complete the sign out log.

Later a review of facility security video for this evening showed the resident walking in the hallways carrying a cat and at 9:42 p.m. the resident exited the side entrance door of the building with the cat.

The resident's death record indicated the cause of death was environmental cold exposure.

During an interview, a staff caregiver stated the resident showed signs of confusion that evening when he kept coming out of his room often carrying a black cat and looking for his brother. The caregiver stated at one point she stopped him from going outside through the side exit door, advised the resident to go back to his room to wait there, and the resident was compliant with her directions. The caregiver stated she completed a final safety check before going home that shift and the resident was in his room at that time.

During an interview, a nurse stated the staff working that night completed the safety checks and followed the facility policy. The nurse stated after the resident's death, the facility policy had been revised to include steps to locate and verify where all residents are if they are not accounted for during a safety check and all staff were trained on the new policy.

During the investigative interview, a family member stated he was unaware of the cat in the resident's apartment until the facility called him the day before the resident's death and informed him of the issue. The family member stated that the resident could come and go freely from the building, but he would not go out in the night alone in cold weather. The family member denied there was family, specifically a niece, which lived in town that he would have walked to.

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, he was deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: The facility made updates to the missing resident facility policy and provided all staff training on the policy.

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:

Office of Ombudsman for Long Term Care

Office of Ombudsman for Mental Health and Developmental Disabilities

Anoka County Attorney

Coon Rapids City Attorney

Coon Rapids Police Department

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25729	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/18/2025
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NAME OF PROVIDER OR SUPPLIER SELECT SR LVG COON RAPIDS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11350 MARTIN STREET NW COON RAPIDS, MN 55433
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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>#HL257294402C/#HL257298123M</p> <p>On March 18, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 73 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued, tag identification 2360.</p>	0 000	<p>Assisted Living Provider 144G. 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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
02360	144G.91 Subd. 8 Freedom from maltreatment	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>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> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident 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. Please refer to the public maltreatment report for details.</p>	02360	<p>REQUEST FOR RECONSIDERATION RECEIVED</p>	
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