Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302176403M
Compliance #: HL302179553C

Date Concluded: January 17, 2025

Name, Address, and County of Licensee Investigated:
Arbor Garden Place
535 Canyon Drive NW
Eyota, MN 55934
Olmsted County

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

Evaluator's Name: Julie Serbus, 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 when began hallucinating and was verbally disruptive with drug paraphernalia in his room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While it was true drug paraphernalia was found in the resident's room, the facility acted appropriately to the resident's behavior and situation. The unlicensed notified the nurse, law enforcement was contacted, and emergency medical services transported resident for medical evaluation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted a family member along with law enforcement and the social worker. The investigation included review of resident record, hospital records, hospital laboratory results, law enforcement notes, and related facility policies

and procedures. Also, the investigator observed general interactions of staff and residents while on site and the location of the resident's apartment in the facility.

The resident resided in an assisted living facility. The resident's diagnoses included tobacco abuse, depression, and history of substance abuse. The resident's service plan included monitoring of vital signs and medication management. The individual abuse prevention plan indicated resident was vulnerable due to use of marijuana and at times displayed behaviors of agitation and verbal aggression towards staff members.

One day on two separate occasions law enforcement was called to the facility. The first call was related to drug paraphernalia found in the resident's room along with changes in the resident's behaviors. A second call to law enforcement was related to the resident's mental status, verbal outburst, and hallucinations. During the second occasion, emergency medical services were called to the facility to transport resident due to unusual body movements and agitation.

The resident's signed assisted living agreement indicated smoking was not allowed in the resident's apartment, common areas or elsewhere on the facility's premises. The same document indicated the resident could not possess nor manufacture controlled substances nor engage in any drug-related activity on or near the premises, or eviction proceedings would result. The presence of any illegal drug, in any amount, in the resident's apartment constituted a violation.

Hospital records indicated that the resident arrived at the emergency department with an altered mental status, slurred speech, and wounds on his legs. The record indicated a positive drug screen on admission. The resident was admitted, and a chemical assessment completed during inpatient stay with a recommendation for outpatient treatment upon discharge.

During investigative interviews, multiple unlicensed caregivers stated the facility provided medication administration for medically prescribed medications. The caregivers gave a consistent account that the resident smoked on his deck which was a violation of the facility policy, and the caregivers were trained to notify the facility management of concerns regarding smoking and/or illegal drug use.

During an interview, the facility nurse stated the resident displayed twitching movements, making strange noises, hallucinating, and saying "something bad" happened to family member. The nurse stated other residents voiced concerns of the erratic behaviors. The nurse stated the smoking and/or substance abuse on the premises was in violation of the facility's policies. The facility staff members found drug paraphernalia in the resident's room out in the open; the resident also did allow facility staff members to search his apartment with him inside.

During an interview, a manager stated the facility discussed the facility policies with the resident but did not to follow the policies.

During an interview, a family member stated the resident smoked marijuana out on his deck and the facility did offer substance abuse treatment. The family member stated he was aware of drug paraphernalia found in the apartment but stated he was not aware of where it came from. Family member stated the resident had wounds on his legs from scratching areas and pulling off scabs along with not taking care of his personal hygiene. Family member stated he was aware the facility did not provide wound care services.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

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, present when family member interviewed.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: NA

Action taken by facility: The facility took steps to discharge the resident.

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
	30217	A. BUILDING: _____ B. WING _____	C 12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GARDEN PLACE	535 CANYON DRIVE NW EYOTA, MN 55934

(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 On December 31, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL302179553C/HL302176403M. No correction orders are issued.	0 000		