Protecting, Maintaining and Improving the Health of All Minnesotans

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State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303425082M
Compliance #: HL303421506C

Date Concluded: October 17, 2025

Name, Address, and County of Licensee Investigated:
Minnesota Greenleaf
1006 Greenwood Street East
Thief River Falls, MN, 56701
Pennington County

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

Evaluator's Name: Angela Vatalaro, 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 alleged perpetrator (AP), a nurse, neglected the resident when the AP failed to obtain orders for extended antibiotic use for the resident's UTI (Urinary Tract Infection.) As a result, the resident's medication was not started timely requiring a clinic visit. As a result, the resident's cancer treatment was delayed for two weeks.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility staff failed to follow their system in place of what to do when medications arrived at the facility from the pharmacy without orders. As a result, the resident did not receive her antibiotic medication treatment for a UTI timely. The resident was seen by a medical provider in a clinic, received an injection of antibiotic, and the resident's scheduled cancer treatment was canceled due to elevated white blood cell count related to the infection.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and the AP. The investigation included review of the resident records, pharmacy records, a personnel file, related facility policy and procedures. Also, the investigator observed the resident and staff interactions with the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included bladder cancer, bladder resection (surgical procedure to treat bladder cancer,) and chemo to bladder/implant. The resident's service plan included assistance with medication administration and coordination of care by the nurse and with other providers. The resident's assessment indicated a licensed nurse was responsible for monitoring medication supply, reviewing new medication orders, and made changes to the medication administration record as needed. The resident was oriented to person, place, and time with a memory problem. The same assessment indicated a nurse helped with health issues, scheduling, and follow-ups.

The resident's record indicated the resident had chemotherapy treatment (infusion therapy) scheduled weekly for bladder cancer. Records indicated the resident's blood and urine would be looked at for signs of infection and this may be done three to four days prior to the appointment. If the resident had signs of infection cancer treatment may be delayed.

The resident's record indicated one day the resident's provider ordered an antibiotic, a supply of 14 capsules to take 1 capsule twice daily for seven days to treat the resident's UTI. Orders provided by the facility included an E-prescription (electronic prescription from a medical provider to a pharmacy). Pharmacy delivery records indicated the resident's 14 capsules of antibiotics were delivered to the facility the same day the E-prescription was received.

The resident's medication administration record (MAR) indicated the resident received a seven-day course of antibiotics as well as additional antibiotic capsules after a supply of the seven-day course was administered.

After the first antibiotic treatment, pharmacy delivery records indicated a 10-day supply of 20 capsules of antibiotics, were delivered. Orders provided by the facility included an E-prescription from the pharmacy. Pharmacy delivery records indicated the resident's 20 capsules of antibiotics were delivered to the facility the same day the E-prescription was received. Seven days after that, the AP documented on the E-prescription to start the antibiotics today per a phone call the AP had with the resident's provider's nurse.

The resident's MAR indicated for the 10-day course there was a duration of five consecutive days the resident did not receive any antibiotic capsules administered by staff for treatment of the resident's UTI.

The resident's MAR indicated during the five consecutive days the resident did not receive the antibiotics, there were 15 medication passes and numerous different staff administering other medications to the resident.

The resident's record indicated the AP spoke with the resident's provider's nurse and indicated the resident's 10-day supply of antibiotics was received and did not get administered, because the provider did not fax the orders to the facility. The notes also indicated the resident received four capsules out of the 10-day medication pack and had an eight-day supply remaining. The resident's record indicated the facility was informed to restart the remainder of 10-day supply of antibiotics.

The next day, records indicated the resident had a low-grade temp of 99.3, the resident said she was not "feeling the best," was tired, and had some weakness. The resident went to the clinic for evaluation.

Clinic medical provider notes indicated the resident was sent in by the facility for concern of ongoing malaise (general discomfort, uneasiness, or lack of wellbeing), fatigue, and low-grade temp. The medical provider indicated the resident was recently treated for UTI. Seven days later another urine lab test was checked, infection was present, so an additional 10 days of antibiotic was ordered but was not started by the facility. The provider's notes indicated, urology indicated they spoke to the facility; the facility received the medication but did not receive an order, so they did not start them. The medical provider notes indicated the antibiotic medication did get restarted the evening prior to the clinic visit and the resident had two doses. The clinic notes indicated the resident's antibiotics were not started timely per the resident's clinic records. The resident and resident's family were unaware of this. The resident received a Rocephin (antibiotic) injection, and the antibiotics were not changed as prescribed.

Clinic visit orders indicated the resident was seen and a urine was rechecked and indicated the resident still had a UTI. The resident received a Rocephin injection and orders included to ensure antibiotics were given to the resident as already ordered.

During onsite compliance interviews, multiple unlicensed staff stated if a medication was delivered from pharmacy, and the medication was not listed on a resident's MAR staff contacted a nurse. Two unlicensed staff also both stated after pharmacy delivery, medications were distributed to a resident's dedicated medication cart.

During an interview, nurse 1 stated she could not tell when looking at the resident's MAR why the MAR indicated more than 14 capsules of antibiotics were administrated during the resident's 7-day course of antibiotics. Nurse 1 said either a medication or documentation error occurred.

During an interview, nurse 2 stated if medications were delivered to the facility from pharmacy and were not on the MAR, and if there was no paperwork or orders from a provider, unlicensed

staff were to contact a nurse. Nurse 2 said within 24 hours medication orders were supposed to be entered by a nurse onto the MAR. Nurse 2 said if the facility did not have an order for the medication delivered, a nurse called the pharmacy or called the medical provider for an order. When the resident's 10-day course of antibiotic arrived and was not on the MAR, nurse 2 said she did not receive a call from unlicensed staff. Nurse 2 said, if she would have received a call, she would have obtained an order, or an order would have at least been obtained within 24 hours to add this to the MAR for administration. Nurse 2 stated from what she reviewed in the resident's record there was a delay in the resident receiving the 10-day course of antibiotic.

During an interview, the AP stated the resident was undergoing cancer treatment for her bladder and required lab work prior to treatment to check if the resident had a UTI. If the resident had a UTI, the bladder treatment was postponed. The AP stated the resident had a UTI, and 7-day course of antibiotics were ordered and administered. The resident had lab work done, the UTI was not cleared, so an additional 10-day course of antibiotics was ordered by the resident's provider. The 10-day course was delivered to the facility from the pharmacy. The AP said the 10-day course of medication was not added to the MAR like it should have been because there was no paperwork from the provider with an order. However, the AP said the facility had a process in place when this occurred, unlicensed staff called a nurse, and a nurse called the provider for an order or called the pharmacy to obtain an E-prescription. The AP said the resident's medication was in the medication cart unadministered, and unlicensed staff did not inform the nursing department of this. The AP said unlicensed staff did not contact the AP or the on-call nurse to let them know antibiotics were present at the facility and were not on the MAR. The AP said the nursing department was unaware the antibiotics arrived and were not on the MAR. The AP said there were multiple errors and said a lot of things went wrong surrounding this incident. The AP said she did not remember how the resident's unadministered antibiotic capsules were discovered. The AP said once it was discovered, she spoke to the resident's provider's office and obtained orders to finish the 10-day course, and the AP also obtained a faxed E-prescription from the pharmacy. When she contacted the provider, the resident had already received doses from the 10-day supply of capsules which the AP said was another error that occurred. The AP said for the consecutive days the resident did not receive her antibiotics; each of those days were also considered errors. The resident's scheduled chemo bladder treatment was canceled. The AP said the resident's antibiotic capsules were delivered and were in the medication cart unadministered. The AP also said the resident went into the walk-in clinic because the resident was not feeling well, the resident was supposed to get medications and was not getting them correctly, so the AP suggested that the resident get evaluated.

During an interview, leadership staff stated she did not have an internal investigation regarding the incident.

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: Yes.

Action taken by facility:
Once the facility learned of the resident’s unadministered antibiotics, the facility obtained orders and resumed the resident’s course of antibiotics. The facility coordinated a visit for the resident at a walk-in clinic.

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
Pennington County Attorney
Thief River Falls City Attorney
Thief River Falls Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30342	A. BUILDING: _____ B. WING _____	C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA GREENLEAF	1006 GREENWOOD STREET EAST THIEF RIVER FALLS, MN 56701

(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: HL303421506C/HL303425082M On September 9, 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 54 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL303421506C/HL303425082M, 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	Continued From page 1 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 reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		