Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303428422M
Compliance #: HL303425200C

Date Concluded: March 21, 2025

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

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

Evaluator's Name: Christine Bluhm, 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:
The facility neglected the resident when it failed to adequately assess and monitor the resident's lower leg injury resulting in swelling, redness and pain.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. A facility nurse looked at the injury and documented the resident stated he bumped his left lower leg resulting in a large purple bruise. The resident did not choose to have it evaluated at that time, so the nurse scheduled the next available appointment with the resident's medical provider. The resident did not alert staff when the wound worsened until another agency nurse made a visit and the resident was then sent in for a medical evaluation.

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

reports, staff schedules, related facility policy and procedures Also, the investigator observed residents and staff during routine activities during a recent visit to the facility.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes, congestive heart failure, atrial fibrillation and lymphedema. The resident's care plan indicated he was independent with personal cares, hygiene and mobility. The care plan also indicated the resident's lower legs were fragile, discolored, bruised easily and he would ask for assistance if he noticed any open areas that needed assessment. The resident's assessment indicated the resident was oriented and could verbalize his needs.

A concern arose the resident had an injury to his leg that had become red, very swollen, blistered and painful to the touch. The report indicated the injury was not monitored and the resident was not provided pain medication for the injury.

During an interview, a facility nurse stated the resident brought the injury to her attention and it appeared to be a bruise. The nurse stated it was not red with no evidence of a clot. She stated follow-up options were discussed at that time with the resident, who did not want it to be immediately evaluated, and she made the soonest appointment with his medical provider that was available. She stated the resident agreed to go in sooner if it worsened.

During interview, a second facility nurse stated she did not receive any concerns from staff or the resident that the injury had worsened or that it needed immediate attention.

During interview, the resident stated he had fallen but could not remember when it happened. The resident said he thought the injury occurred then and the nurse looked at it. The resident stated he did not think it was bad at the time and never really told anyone about it.

In conclusion, the Minnesota Department of Health determined neglect was 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.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action taken.

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
	30342	A. BUILDING: _____ B. WING _____	C 03/06/2025

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 On March 6, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL303425200C/#HL303428422M and HL303424361C/#HL303428142M. No correction orders are issued.	0 000		