Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304189482M
Compliance #: HL304183740C

Date Concluded: April 21, 2026

Name, Address, and County of Licensee Investigated:
Thorne Crest Senior Living
1201 Garfield Avenue
Albert Lea, MN 56007
Freeborn County

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

Evaluator's Name: Lena Gangestad, 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 alleged perpetrator (AP) neglected the resident by not following the fall protocol after finding the resident on the floor, including not documenting the incident or notifying the nurse.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. An unwitnessed fall occurred, after which the resident was found on the floor and assisted back to bed. The AP reported the incident to the incoming unlicensed caregiver. The unlicensed caregiver then notified the nurse, and hospice services were later contacted.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigation included review of the resident's records, internal investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.

The resident, who resided in a memory care unit of an assisted living facility, had diagnoses including dementia. The service plan indicated the resident required assistance with all activities of daily living. The plan also indicated the resident could ambulate independently with a four-wheel walker or receive one-person assistance as needed. The resident was able to request help when needed.

One day the AP found the resident on the floor after an apparent unwitnessed fall.

During an interview, the facility manager stated the AP stated she was walking past the resident's room and observed the resident on the floor. The AP said she obtained a vital signs machine, checked the resident, and reported that the resident's vitals and overall condition appeared normal. The AP then assisted the resident back to bed. The AP stated she did not administer pain medication due to lack of access and acknowledged she did not notify the nurse. The manager also said both the unlicensed caregiver and the nurse were aware of the incident.

During an interview, the unlicensed caregiver stated the AP told her she heard a clock alarm sounding, followed it, and found the resident on the floor under the sink. The AP stated she checked the resident, took vital signs, and assisted her back to bed. The unlicensed caregiver also said the resident had been experiencing ongoing pain for approximately one week prior to the fall and continued to report pain throughout the night. After being informed of the incident, the unlicensed caregiver notified the nurse, who then contacted hospice.

During an interview, a family member stated they were unaware of the fall but expressed no concerns regarding the care the resident was receiving.

Hospice documentation indicated a facility staff member reported the resident had an unwitnessed fall. The resident denied pain at the time of assessment, and no injuries were noted. The same document indicated range of motion and vital signs were within normal limits. A PRN (as-needed) visit was assigned for the next day, and the nurse case manager was updated.

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: No, the resident was no longer at the facility.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, attempted but did not reach.

Action taken by facility: No action required.

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
	30418	A. BUILDING: _____ B. WING _____	C 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNE CREST RETIREMENT CENTER	1201 GARFIELD AVENUE ALBERT LEA, MN 56007

(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 5, 2026, the Minnesota Department of Health initiated an investigation of complaints #HL304189482M/HL304183740C. No correction orders are issued.	0 000		