Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305911300M
Compliance #: HL305911900C

Date Concluded: June 24, 2025

Name, Address, and County of Licensee Investigated:
Elmhurst Commons Apartments
400 3rd Street SW
Braham, MN 55006
Isanti County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela R.N.
Special Investigator

Finding: Inconclusive

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):
Facility staff emotionally abused the resident when they refused to allow the resident to leave for the airport and discharge from the facility with medications until the facility bill was paid.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. There was not enough evidence provided to determine if abuse occurred as conflicting accounts of the incident were provided and the resident's family declined that the resident be interviewed. However, the facility bill was paid and the resident discharged with all medications from the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record(s), personnel files, staff schedules and related facility policy and procedures. Also, the investigator observed the facility environment and staff interaction with residents.

The resident resided in an assisted living facility. The resident's diagnoses included parkinsonism, spinal stenosis, and anxiety. The resident's service plan included assistance with laundry, housekeeping, and medication management. The resident's assessment indicated the resident was alert and oriented, independent with activities of daily living, (ADLs), mobility, transfers and toileting. The resident's assessment indicated the resident's family member assisted with financial decisions.

The resident's medical records indicated the resident gave a thirty-day notice four days prior to her discharging from the facility and the resident's thirty-day notice did not indicate a date or time of her expected discharge.

The resident's medication administration records indicated the resident received scheduled morning medications at 9:00am on the date of her discharge. The resident's medical records indicated the resident received all her medications at 10:09 a.m., at the time of the resident's discharge.

The resident's facility billing invoice for services indicated the resident made a payment for services on the date of her discharge.

During an interview, an unlicensed staff member who cared for the resident the evening before the resident's discharge, stated the resident had a visitor but did not know the name of that visitor and did not have any interaction with this visitor. That evening, the staff member recalled the resident was packing what the resident referred to as a "bug-out" bag and informed the staff member that she was moving to another state and family would be at the facility at 7:00 a.m. to pick her up and bring her to the airport. The staff member did not report the packing or the resident's statement to her supervisor because the resident had displayed cognitive issues in the past and could be incoherent.

During an interview, facility unlicensed staff, who cared for the resident stated she was unaware of the resident's discharge until she was informed by family at approximately 8:50 a.m., that the resident would be discharging on that day and the family requested all the resident's medications "right now," for the resident's discharge. The unlicensed staff stated she informed an administrative nursing staff immediately then gave the resident her scheduled morning medications at approximately 9:15 a.m., while the administrative nurse prepared the resident's medications for discharge.

During an interview, the resident's family member stated she verbally informed a facility manager of the resident's discharge date, four days prior to the resident's discharge. The family member stated she also informed another family member to handle the resident's medication preparations for the resident's discharge approximately two to three days prior to discharge. The family member stated they arrived at the facility at approximately 8:45 a.m. and informed staff the resident needed to be discharged between 9:00 a.m. and 10:00 a.m. in order to board

a plane by 1:29 p.m. Staff informed the family and the resident, that resident could not have her medications until the facility's bill of services was paid in full with a cashier's check. The family then met facility administrative staff, and went to the resident's bank to obtain a cashier's check and returned to the facility at approximately 9:45 a.m. Upon return from the bank, facility administrative nursing staff had the resident's medications and medication instructions ready, and the resident was on time to board her plane. However, the family member asked that the resident not be interviewed as they did not want to upset or concern the resident over the incident again.

During an interview, facility management recalled being informed by the resident's family the evening prior to the resident's discharge and spoke with the family member, who was in charge of the resident's finances regarding the resident's bill of services. The day of discharge, the management staff asked the family to pay the resident's bill and was offered a check from the resident's bank account. However, management staff informed the family that due to the checks being returned preferred payment was in the form of a cashier's check. A cashier's check was obtained from the resident's bank account by the family and the bill was paid prior to the resident's discharge that morning.

The resident was not interviewed per family request.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No, per financial POA, per the resident's cognition and anxiety.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator, AP-1 and AP-2, interviewed: Yes

Action taken by facility:
The facility nursing staff had prepared all of the resident's medications and medication instructions within the time-frame given by the resident's family 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
	30591	A. BUILDING: _____ B. WING _____	C 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMHURST COMMONS APARTMENTS	400 3RD STREET SW BRAHAM, MN 55006

(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 May 7, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL305911900C/#HL305911300M. No correction orders are issued.	0 000		