Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307071501M
Compliance #: HL307072348C

Date Concluded: July 11, 2025

Name, Address, and County of Licensee Investigated:
Oak Park Place
1615 Bridge Avenue
Albert Lea, MN 56007
Freeborn 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 he left the facility one night. The resident was found lying in the street and found by a citizen.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident admitted to the facility on the day of the incident and although he expressed, he wanted to return to his home, there was no indication that he was going to leave the facility without staff knowledge or in an unsafe manner. The resident was not injured. The resident was moved to the facility's memory care unit after the elopement.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted the case worker. The investigation included review of the resident record, hospital records, facility incident reports, staff schedules, and related

facility policy and procedures. Also, the investigator observed resident daily activities and resident/staff interactions both in the general AL and the memory care.

The resident resided in an assisted living and admitted to an apartment in the assisted living part of the facility. The resident's diagnoses included depression, heart valve stenosis with recent valve replacement and a pacemaker. The resident's service plan included assistance with medications. The resident's assessment indicated he was independent with mobility and personal cares. The resident was disoriented to place and time, impulsive, and had poor decision-making skills and at times was resistive to redirection.

Review of a facility report indicated the resident eloped from the assisted living facility six hours after he was admitted. A taxicab driver brought him back after finding him lying in the road. The resident was moved into the locked memory care unit.

Review of the resident's discharge summary records from a skilled rehab facility indicated he was discharged from the skilled facility to the assisted living with fall risk precautions, cognitive deficits and pacemaker. Prior to the rehab stay, the resident presented to the emergency room after a fall and consequently found to have severe aortic stenosis. He was transferred to a higher-level hospital for surgical aortic valve replacement as well as pacemaker placement. The resident was noted to have very poor short-term memory and could not recall his time in the hospital. A doctor recommended a nursing facility as the best option. The nursing discharge summary indicated the resident had diabetes, a recent fall, cognitive impairment, depression and an appointed guardian.

During an interview, the nurse stated he had completed an in-person pre-admission screening while the resident was in the hospital. On the day of admission to the facility, the resident was oriented to self only, was restless and agitated and made statements that he did not want to be there and wanted to leave. The nurse stated he was able to comfort him with food and other necessities. The transfer paperwork indicated the resident verbalized wanting to leave the skilled rehab facility but was able to be redirected.

During interview, a manager stated the hospital referral indicated the resident needed medication management and that he had been malnourished living at home. The transfer paperwork from the skilled rehab facility indicated the resident was exit-seeking and a wander guard was placed on him. The manager stated they were not aware of this until they read it in the transfer paperwork. The resident arrived alone without anyone with him until the guardian showed up later. He wanted to go home but was agreeable to stay. The manager stated the resident walked around outside a couple of times and came back in to eat supper. Then a little while later, a taxi driver came and said he knew the resident and found him lying in the middle of the road (approximately eight blocks away). The resident said he was tired and did not know where he was.

The resident was interviewed and stated he did not know why he was at the facility and wanted to return to his home.

During interview a family member stated the resident cannot return to his home. The family member stated the resident is a little higher-level functioning than the other residents in the memory care and would like to find a place more suitable for him. The family member also stated the day the resident left the facility, he was sitting on the curb and denied being found lying in the road. The family member stated the incident was exaggerated and believes the resident was not found in such an unsafe manner.

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:
After the incident and the resident returned to the facility, the facility provided one to one supervision to the resident for the remainder of the night. The facility admitted the resident to the secured memory care unit with elopement precautions.

Action taken by the Minnesota Department of Health:
No 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
	30707	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE OF ALBERT LEA	1615 BRIDGE 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 May 21, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL307072348C/#HL307071501M. No correction orders are issued.	0 000		