DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307457202M
Compliance #: HL307452220C

Date Concluded: February 13, 2025

Name, Address, and County of Licensee Investigated:
Lino Lakes Assisted Living
725 Town Center Parkway
Lino Lakes, MN 55008
Anoka County

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

Evaluator's Name:
Maerin Renee, 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 facility neglected the resident when the resident eloped from the facility. The resident was outside for an unknown amount of time and developed frostbite and hypothermia. The resident was hospitalized and died in the hospital 11 days later.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident was assessed to require safety checks every two to three hours. However, the facility failed to direct staff to check on the resident every two to three hours and instead staff were directed to check on the resident as needed (PRN). The resident eloped from the facility and facility staff were not aware the resident was missing until a neighbor found the resident lying outside. The resident was sent to the hospital and died 11 days later.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted family. The investigation included review of the resident records, death record, hospital records, the facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident interactions with staff.

The resident resided in an assisted living facility. The resident's diagnoses included dementia. The resident's services included assistance with activities of daily living, transfers, toileting, meals, and medication management. The resident's assessment indicated he required safety checks every two to three hours.

The facility's internal investigation indicated the resident was admitted to the facility with moderate cognitive decline and a history of falls related to hypotension (low blood pressure). Early one morning a neighbor entered the facility and requested help because he found someone lying outside in the cold. A staff member went outside with the neighbor and identified the individual lying on the ground as the resident. The resident was dressed in long pants, a light jacket, a shoe on one foot, and a sock on the other foot. The resident had exited the building without being observed by staff. Staff documented the resident was alert but disoriented. Staff called 911 and emergency medical services (EMS) transported the resident to the hospital. Staff told EMS the resident did not have scheduled safety checks, but staff saw him during meals and medication passes. Staff noted no injuries at the time of the event. The resident did not have a known/reported history of wandering and was not deemed an elopement risk prior to the incident.

The nurse who completed the resident's admission assessment said neither she nor the resident's family were concerned about wandering behaviors. Although she documented in the assessment that the resident required safety checks every two to three hours, this was not communicated to staff.

One staff member said she completed rounds at approximately 10:00 p.m. the evening prior and the resident was in his room. The resident's medication administration record (MAR) indicated he received bedtime medications at 10:05 p.m. Overnight staff reported no one saw the resident during the night and into the next day. At 7:30 a.m. a day staff member was alerted by a neighbor that the resident was lying on the ground outside. The staff member notified other staff members for help, staff called EMS and notified the on-call nurse.

AccuWeather.com reported the temperature in Lino Lakes the day the resident was found outside had a low of -14 degrees below zero Fahrenheit and a high of -8 degrees below zero Fahrenheit.

The resident's nursing assessment at admission (less than a month before his elopement) indicated the resident was not at risk for elopement, but was at risk for falls due to dementia. The nurse assessed the resident as needing safety checks every two to three hours. Staff were

also to ensure resident at scheduled meals and activities. Referral documents indicated the resident experienced moderate cognitive decline, had a history of falls, and was able to follow one- to two-step commands. The resident was not always oriented and required reminders for redirection and orientation on an as-needed basis. The resident had mild to moderate disorientation and difficulty recalling/retaining information, and displayed deficits in judgement. The facility nurse assessed the resident as capable of independent decision-making and not at risk for elopement.

The resident's service plan indicated a goal for the resident was to maintain safety while living in community. Safety checks every two to three hours were documented as a service that would be provided by the facility. A goal was that resident would not leave the community unattended, and staff were to observe the resident's location in the community at meals and during activities.

Progress notes indicated the resident was admitted to the facility after being hospitalized for several months due to low blood pressure, falls, and increased memory loss. The admitting nurse reviewed the resident's service plan with a family member and staff were to follow the plan of care for services. Staff documented one fall in which the resident did not sustain any injuries. After the resident was found lying outside, staff stated they did not know how long the resident was outside, and the resident was confused and disoriented. The resident was taken to the hospital for further evaluation.

The resident's abuse prevention plan indicated the resident was at risk of self-abuse because he lacked self-preservation skills and ignored personal safety. The resident's diagnosis of dementia was cited as the reason he was at risk for potential maltreatment.

The resident's task record (which directed staff on resident specific care needs) directed staff to do safety checks as needed, not every two to three hours as assessed on the resident's service plan. No safety checks were documented the first month the resident lived at the facility, nor for the day the resident was found outside. However, safety checks were documented for two days after the resident was admitted to the hospital and was no longer at the facility. Several other tasks were documented as having been completed by staff for up to three days after the resident had left the facility, including dressing, meal attendance, personal hygiene, transferring, and group engagements.

The resident's hospital record indicated he was admitted in critical condition with hypothermia, frostbite, right-sided pneumothorax (collapsed lung), and evidence of head trauma as indicated by a hematoma on the left side of his forehead. Due to the severity of the resident's frostbite, he was referred to the hospital's burn team. The resident's core temperature upon admit was 28 degrees Celsius (82.4 degrees Fahrenheit). The resident had several areas of frostbite and blisters to his back, flank, feet, legs, and hands. During his hospital stay, he went into cardiac arrest, from which he was resuscitated, and then suffered cardiogenic shock (when the heart

cannot pump enough blood and oxygen to the brain and other vital organs). The resident died at the hospital 11 days after admission.

The resident's death record indicated the resident's immediate cause of death was complications of resuscitated cardiopulmonary arrest, due to environmental cold exposure (hypothermia). The manner of death was documented as an accident.

When interviewed, a nurse stated the resident had not lived at the facility for very long prior to the elopement and was "pretty independent." The nurse said, among other services, the resident received safety checks every two hours. During the internal investigation, the nurse spoke with several staff members, none of whom had seen the resident on the overnight shift, or in the morning when they drove in for the day shift. A neighbor had brought the resident to the attention of facility staff and staff addressed the elopement per protocol.

When interviewed, an overnight staff stated the resident did not have safety checks, but he was scheduled to be toileted on the overnight shift. However, the resident declined this service because he did not want to be awakened during the night. The overnight caregiver stopped checking on the resident and continued to document the resident declined toileting on the overnight shift without continuing to ask the resident.

When interviewed, a day shift staff stated she did not see the resident outside, since she drove in a different way from where the resident was located. Staff attended to the resident per protocol after he was found. The day shift staff stated the resident did not have scheduled safety checks, but did have as needed safety checks at the time of his elopement.

When interviewed, a family member stated he visited the resident the day before the elopement and left around dinner time. The resident was in good spirits at that time. The family member stated he was under the impression the resident had safety checks every two to three hours.

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: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
All residents were assessed for the need of safety checks, safety checks were instituted, and tasks were created in the plans of care so staff could document completion of safety checks. Staff received refresher training in missing resident, emergencies, and vulnerable adult maltreatment policies.

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
Anoka County Attorney
Lino Lakes City Attorney
Lino Lakes Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30745	A. BUILDING: ______ B. WING ______	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINO LAKES ASSISTED LIVING	**725 TOWN CENTER PARKWAY LINO LAKES, MN 55014**

(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: #HL307452220C/#HL307457202M On January 23, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 66 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL307452220C/#HL307457202M, 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 Residents have the right to be free from physical,	02360		

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LINO LAKES ASSISTED LIVING	**725 TOWN CENTER PARKWAY LINO LAKES, MN 55014**

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02360	Continued From page 1 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 was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		