

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL312218842M
Compliance #: HL312211926C

Date Concluded: March 20, 2026

Name, Address, and County of Licensee

Investigated:

Carefree Cottages of Maplewood
1801 Gervais Avenue
Maplewood, MN, 55109
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, 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 facility neglected a resident when they failed to provide supervision. The resident eloped and law enforcement found him in the community approximately six hours later.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The resident received minimal services and required no mobility restrictions. The resident left the facility on his own, which was not unusual for him. Hospital records indicated acute (sudden) illness caused the resident to become confused.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and case workers. The investigation included review of the resident records, hospital records, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility

policy and procedures. Also, the investigator toured the facility and observed the exits, staffing levels, and medication administration.

The resident resided in an assisted living facility. The resident's diagnoses included seizures, diabetes, and communication difficulties. The resident's service plan included assistance with medication management, meals, and grooming. The resident's nursing assessment indicated the resident had "mild" memory loss and was forgetful. The resident dressed himself and walked independently. The resident had no history of elopement.

Hospital records indicated the resident arrived in the ER late in the evening and said he was outside for "a long time," but he could not remember why he was outside. Hospital records indicated facility staff told them they saw him leave around supper time and they thought he was going out with his family. The records indicated approximately six hours later, law enforcement found him in the community, inappropriately dressed for the cold weather. An ER physician evaluated him and determined he did not have the "frostbite," so they wanted to return him to the facility. The ER physician then discovered it was unusual for the resident to be this confused, so they completed further medical testing and determined the resident had pneumonia. The resident then admitted into the hospital. The records indicated, the resident had been sick with "cold" symptoms, prior to this incident. The resident remained in the hospital for six days then returned to the facility.

Additional physician visit records indicated the residents diagnoses also included acute metabolic encephalopathy (sudden onset of confusion).

The resident's service plan records indicated the facility started providing safety checks every two hours upon his return to the facility.

During an interview, a nurse said the night prior to the incident, a staff member called her and told her the resident appeared a little confused about his evening medications when she gave them to him, but this was not unusual, so the nurse told the staff member to check on him in a few hours. The nurse said the staff member checked on him again, and the resident appeared to have improved. The nurse said the following afternoon, just prior to supper, a staff member called her and said the resident did not "seem like himself," but the resident denied having any pain or any need for further medical evaluation. The nurse said she told the staff member to "keep an eye on him" and call her with any changes. The nurse said later in the evening a staff member called her because they were unable to locate him to give him his evening medications. The nurse said the staff member told her they checked his room, and the lower level of the facility. The nurse said she told the staff member he could have gone out with his family and asked them if they checked the logbook (where resident's sign out when they leave the facility) or called his family. The staff member had not checked the book, or called his family. The nurse told the staff member to call back when they found him. The nurse said it was about an hour later when the staff member called her and told her law enforcement found the resident and brought him back to the facility. The nurse said the resident's family decided he

should go to the hospital, so they sent him to the emergency room (ER). The nurse said prior to this incident, the resident was able to “come and go” freely from the facility and often left for various outings. The nurse said this was an isolated incident.

During an interview, a family member said the resident had a “cold” prior to this incident, but nothing else seemed unusual. The resident was gone from the facility for approximately six hours, but he did not have frostbite (skin damage from cold weather). The family member said the resident often walked to the library or a local grocery store, so he could have been at those locations during this time frame. The family member said the resident could have become disorientated upon his return to the facility. The family member said the resident did not require restrictions on his mobility and often left for various outings. The family member said this was an isolated event due to an acute (sudden) illness. The family member said, after this incident, the facility implemented scheduled safety checks. The family member said the resident was doing well, at his baseline health status, and there were no further elopements.

Multiple investigative interviews indicated this event was unusual for the resident and he had no history of elopement concerns.

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:

The facility implemented safety checks and re-educated staff members about policies and procedures.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31221	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/17/2026
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NAME OF PROVIDER OR SUPPLIER CAREFREE COTTAGES OF MAPLEWOOD CHA	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 GERVAIS AVENUE LITTLE CANADA, MN 55109
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(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	<p>Initial Comments</p> <p>On February 17, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL312211926C/#HL312218842M. No correction orders are issued.</p>	0 000		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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