Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL314176465M
Compliance #: HL314172185C

Date Concluded: October 30, 2023

Name, Address, and County of Licensee Investigated:
Elmore Assisted Living
202 East North Street
Elmore, MN 56027
Faribault County

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

Evaluator's Name: Deb Schillinger, 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 the resident when the facility failed to properly supervise the resident and subsequently the resident jumped from a third story window.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident did jump from a third story window, the facility could not have reasonably anticipated this action the resident's attempt to leave the building through this means and had performed safety checks as outlined in his service plan.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's guardian, family member, ambulance staff, hospital staff and law enforcement. The investigation included review of the resident's record, staff schedules, facility policies, facility incident reports and

internal investigation. Also, the investigator toured the facility and observed interactions between residents and staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included history of alcohol use disorder with impaired decision making. The resident's service plan included assistance with medication management, and verbal reminders to complete personal cares. The resident's assessment indicated the resident had no mobility issues and was able to walk independently.

The facility incident report indicated the resident attempted to scale down the building from a third story window using blankets tied to a broom. An unlicensed caregiver heard the resident calling for help when she went outside on a break and found the resident on the ground with visible injuries. The resident stated his intention was to leave and go to a store. The facility contacted emergency medical services, who transported the resident to the hospital. There was no facility video available.

The resident's care plan indicated scheduled wellness checks three times daily, one time on each shift. The resident's risk assessments indicated he was a low risk for elopement and falls.

During an interview, an unlicensed caregiver stated he observed the resident, and a fellow resident were walking down the hallway minutes before the incident. The two residents went into the sensory room to listen to music, meanwhile the unlicensed caregiver went to provide a third resident cares. A few minutes later he learned the resident was found on the ground outside over the walkie-talkie. The unlicensed caregiver stated the resident was not exit-seeking earlier that day, received a medication earlier for acting anxious, and gave no indication of attempting to leave through the window.

During an interview with the nurse, who was on-call at the time of the incident, stated the third story window in the sensory room was examined just after the incident and was found slid open from its tracks inward with the screen was out of the window. The nurse presented the investigator with the bracket which was found after the incident that had been pried off the window.

During an interview, the resident stated he found the window open and decided to try to get outside by using a broom with a blanket tied to it. Unfortunately, this did not hold, and he fell to the ground.

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 added additional brackets to all the windows in the secured unit to prevent unauthorized opening.

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
	31417	A. BUILDING: _____ B. WING _____	C 09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORE ASSISTED LIVING	202 EAST NORTH STREET ELMORE, MN 56027

(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 September 20, 2023, the Minnesota Department of Health initiated an investigation of complaint HL314172185C/ HL314176465M. No correction orders are issued.	0 000		