Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326477005M
Compliance #: HL326473314C

Date Concluded: February 14, 2024

Name, Address, and County of Licensee Investigated:
Homestead Assisted Living Memory Care
5530 Ballington Blvd NW
Rochester, MN 55901
Olmsted 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 did not supervise the resident and he eloped through a window.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident did remove a window and was able to get into the parking lot, the resident had not done this previously and the facility could not have reasonably anticipated this.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted hospice personnel and the resident's family. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, related

facility policy and procedures. 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 Alzheimer's disease and brain cancer. The resident's service plan included assistance with medication management and safety checks. The resident's assessment indicated he was disoriented to place and time and ambulated independently with the assistance of a walker.

One afternoon a nurse observed the resident outside the building on facility grounds without supervision. The nurse went outside and returned the resident to the memory care unit. The same report indicated the resident had removed the window in his room from the slides and climbed out the window in his room.

Prior to the elopement, the resident's care plan indicated safety checks were being completed every shift by unlicensed caregivers. After the elopement, safety checks were increased to be hourly, and hospice made medication changes to help manage the resident's behaviors. The facility maintenance team added security features to his window.

The medical records indicated the resident attempted to leave the facility on other occasions, which included an instance when the resident broke a windowpane in his attempt to leave the building. The facility determined the resident would be more appropriate for a different setting and the resident was discharged. The resident continued to decline in the new setting and passed away approximately one week later.

During an interview, a nurse stated the resident had removed the window removed from the tracks and crawled outside. The nurse stated the glass of the window was not broken, nor was the resident injured.

During an interview, a family member stated increasing behaviors that required a transfer to a different setting to manage his care, where his condition continued to decline.

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

Action taken by facility:
The facility maintenance team made changes to the window and the facility added additional safety checks.

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
	32647	A. BUILDING: _____ B. WING _____	C 01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT ROCHESTER	5530 BALLINGTON ROAD NW ROCHESTER, MN 55901

(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 January 2, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL326473314C/#HL326477005M and #HL326472819C/#HL326476806M. The following correciton order is issued for HL326476806M: 2360.	0 000	No plan of correction required.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, 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 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	No plan of correction required.	

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