

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL396786042M
Compliance #: HL396784360C

Date Concluded: December 2, 2025

Name, Address, and County of Licensee

Investigated:

Spirit Care Homes
3727 Shady Oak Road
Minnetonka, MN, 55305
Hennepin County

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

Evaluator's Name: Angela Vatalaro, 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 staff failed to provide adequate supervision. As a result, the resident eloped and sustained injury.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The resident exited the facility through a secured door that was released per fire safety code after sustained pressure while the unlicensed personnel (ULP) was assisting another resident. The ULP responded to the alarm within five minutes and found the resident outside the front entrance sitting on her buttocks. The resident had an unwitnessed fall, sustained a head laceration (cut) and bruise, a shoulder abrasion (scrape), knee and ear skin tear. The resident diagnosed with a wrist fracture. The facility took action to reduce the risk of reoccurrence.

The investigator conducted interviews with facility staff members including administrative staff and nursing staff. The investigation included review of the resident records, facility internal

investigation, facility incident reports, hospice records, staff schedules, video footage, and related facility policy and procedures. Also, the investigator observed the resident and observed exit doors and alarm systems.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with safety checks. The resident's assessment indicated the resident was at risk for elopement and wandered. On occasions, the resident wandered towards exit doors attempting to open them. When the resident heard the alarm, she backed away from the door. Interventions included if the resident exit sought staff were to offer the resident something to eat/drink, offer a movie, or magazine to read. The resident's strength and endurance varied and was unpredictable. At times the resident was able to walk steady, other times the resident was weak. The resident used a wheelchair and required staff assistance with a gait belt when she walked. The resident was disoriented and had severely impaired decision making. The resident received hospice services.

A 20 second video clip with audio showed the resident walk and stand at the front entrance. The resident turned, pulled, and pushed the door and door handle. The door alarm sounded and continued to sound. The resident turned around and walked away from the door. Three minutes later, a 9 second video clip with audio showed the resident standing at the front entrance with the door alarm sounding. The resident turned the door handle, opened the door, and exited.

The resident's incident reports indicated prior to the resident's elopement, the resident had just finished a meal, was sitting in her wheelchair at the dining table, and was calm. The ULP went upstairs to assist another resident. Upon return five minutes later, the resident was not seated in her wheelchair like she had been when last seen. The front entrance door alarm was sounding. The ULP went to the front door. The resident was sitting outside on her buttocks at the bottom of the front entrance stairs. The ULP assisted the resident back into the facility. The nurse assessed the resident after the fall, cleansed the resident's head laceration, and applied a dressing. The resident had range of motion. The resident was provided pain medication. Hospice services were called and went to the facility the same day. The facility nurse and hospice nurse conducted a full skin assessment. The next day, the resident started guarding her right wrist and had pain. A portable x-ray was ordered and the resident diagnosed with a wrist fracture.

The resident's scheduled services record indicated the resident received safety checks the day of the incident.

The resident's hospice records indicated the day of the elopement, there was a duration of five minutes from when the exit door alarm went off to when the resident was found outside by the ULP. Outside, the resident had an unwitnessed fall. Records indicated the weeks following the incident, the resident's head laceration scabbed over, showed healing, with no more bruising. The resident received additional pain medication and wore a wrist brace. The same records

indicated the resident's wrist fracture pain was well managed and the added pain medication eventually discontinued. The records also indicated the facility monitored the resident closely for falls and for pain.

The resident's medical provider records indicated the resident was seen after the incident.

The resident's record did not indicate any prior or further elopements.

During an interview, leadership stated when the secure door alarms the lock will disengage after 15 seconds due to life safety code. Staff need to swipe their badge to reengage the lock and shut off the alarm. Leadership stated ULP followed the facility's protocol and did exactly what he was supposed to in the event of an elopement. After the ULP finished assisting the other resident in the bathroom and ensured resident was safe, he responded to the door alarm. The ULP found the resident outside and assisted her back inside. Leadership stated the secure door alarm system was working the way it was supposed to. Prior to this incident, the resident had not gotten up and walked for months.

During an interview, a nurse stated the resident had a history of exit seeking behavior when she was more mobile, however prior to the incident had not exit sought for several months. The nurse said during this same timeframe the resident's impulsiveness of getting up to walk had also dissipated. She said it was a surprise to everyone the resident was able to get up, walk, and exit the door. During shift, the nurse said she had seen the resident prior to the incident and said there was nothing different or abnormal going on. The resident was at her normal baseline. The resident was last seen by ULP sitting in her wheelchair at the dining table and had just finished eating a meal. The resident was calm. The nurse said the resident had no prior elopement nor any further elopement at the facility. The nurse said the resident was outside for five minutes or less before being found by unlicensed personnel. The nurse said interventions were added.

During an interview, a family member stated she did not have any concerns with staff supervision of the resident. The resident had not had any other elopement outside of this incident and said she was surprised the resident physically got up and walked.

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. Attempted, unable due to cognition.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility installed an additional annunciator to ensure alarms were audible in all areas. The facility contacted the alarm door vendor to review possible system enhancements. The facility implemented routine elopement drills and refresher training. The facility also conducted missing person drills with their staff. The facility added monthly testing and validation of wander management technology systems and alarms.

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: 39678	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/17/2025
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NAME OF PROVIDER OR SUPPLIER SPIRIT CARE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3727 SHADY OAK ROAD MINNETONKA, MN 55305
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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 November 17, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL396784360C/#HL396786042M. No correction orders are issued.</p>	0 000		

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