Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL397141001M
Compliance #: HL397149963C

Date Concluded: June 9, 2025

Name, Address, and County of Licensee Investigated:
Atlas Villas Memory Care
1825 Main Street
Centerville, MN 55038
Anoka County

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

Evaluator's Name: James Larson, RN
Special Investigator

Finding: Inconclusive

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 infection control measures. The resident was hospitalized after contracting COVID-19 and Pneumonia. The resident passed away in the hospital weeks later.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. There was not a preponderance of evidence to support that the actions of the facility staff met the definition of neglect. Conflicting accounts of the incident were provided and it could not be determined if staff failed to use appropriate infectious disease precautions and available personal protective equipment (PPE) while caring for residents.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigation included review of the resident record, facility incident

reports, personnel files, and related facility policy and procedures. The investigator toured the facility, as well as observed staff interactions and provision of care.

The resident resided in an assisted living facility memory care unit. The resident's diagnoses included Parkinson's disease and Alzheimer's disease. The resident's service plan included safety checks, medication administration, laundry, housekeeping, and meal reminders. The resident's assessment indicated she remained independent and staff were to provide reminders and cues when needed.

Documentation indicated that one morning the resident began showing symptoms associated with a common cold, such as fatigue, body aches, congestion, and a runny nose. The resident also reported to facility staff that she was not hungry and didn't want to eat breakfast. Nursing staff at the facility assessed the resident and she was found to not have a fever, although other vital signs were not within normal limits. A COVID-19 test was conducted at the facility which indicated the resident was COVID-19 positive. The facility contacted the resident's family, and it was determined that the family would bring her to a local hospital for evaluation. At the hospital, the resident was prescribed an antibiotic related to a new diagnosis of pneumonia and returned to the facility. Days later, the facility again contacted the family when the resident showed signs of a change in condition and emergency medical services (EMS) were required to transport the resident back to the hospital. The resident admitted to the hospital and required intensive care until she passed away weeks later.

During an interview, a nurse stated that after the resident tested positive for COVID-19 the facility began testing all staff and residents which identified other positive cases. Infection control procedures were implemented although not all precautions met state and federal COVID-19 guidelines. The nurse stated that due to the acuity and diagnosis of other resident, quarantine efforts were not successful at all times and also acknowledged that the facility allowed staff members who previously tested positive for COVID-19 to return to work at their own discretion.

During an interview, an unlicensed staff member stated that although she was not present during the incident in question, she was aware of facility infection control policies and trained on infection control procedures as part of the facility onboarding process.

During an interview, a family member stated that she was made aware of an outbreak of infectious disease at the facility by the nursing staff, as well as the change in conditions of the resident. The family member stated that during a visit the day before the resident was sent back to the hospital, she recalled staff persons exhibiting signs of illness and noticed that not all were wearing personal protective equipment (PPE) while performing resident care tasks.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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, deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility contacted the resident’s family when a change in condition was observed and continued to monitor and advised the family when a higher level of care was needed.

Action taken by the Minnesota Department of Health:

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39714	A. BUILDING: _____ B. WING _____	C 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS VILLAS MEMORY CARE	1825 MAIN STREET CENTERVILLE, MN 55038

(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: #HL397149963C/#HL397141001M On May 7, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 13 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL397149963C/#HL397141001M, tag identification 0510.	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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted healthcare, medical, and nursing standards for infection control and current recommendations for COVID-19. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death),and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included Parkinson's disease, Alzheimer's disease, COVID-19, and pneumonia R1's service plan dated October 1, 2024, included safety checks, medication administration, laundry, housekeeping, and meal reminders.	0 510		

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0 510	Continued From page 2 On November 15, 2024, facility nursing staff assessed R1 and a COVID-19 test indicated the resident was COVID-19 positive. During an interview on May 7, 2025, at 11:15 a.m., registered nurse (RN)-B confirmed she was the facility's infection control nurse. RN-B stated R1 who had tested positive for COVID-19 on November 15, 2025, and was the first known case at the facility. RN-B stated that additional facility staff and residents were tested, and other positive cases were identified. RN-B went on to state that during the COVID-19 outbreak that effected both staff and residents recommendations were not followed including but not limited to: - residents were not required to were masks in common areas due to diagnosis and preference -meals were continued to be served in a communal dinning area with out following a six foot barrier between residents. -screening visitors to the facility did not include temperature checks before entering. -staff were instructed to return to work if they felt they were able due to the number of existing cases already at the facility. The Center for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated May 8, 2023, source control masks and physical distancing are recommended for everyone in a health care setting. It also indicated that in facilities located in counties with substantial or high COVID-19 transmission, health care workers should wear eye protection that covers the front and sides of the face during all patient care encounters. It also	0 510		

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0 510	Continued From page 3 indicated every facility should establish a process to identify anyone entering the facility who had a positive COVID-19 test, symptoms of COVID-19, or who had close contact with someone with SARS-CoV-2 infection. The Minnesota Department of Health (MDH) COVID-19 Personal Protective Equipment (PPE) and Source Control Grids for Congregate Care Settings document dated December 7, 2021, indicated health care workers should wear facemasks, and in facilities located in counties with substantial or high COVID-19 transmission, should also wear eye protection that covers the front and sides of the face. No further information was provided. Time Period for Correction: Seven (7) days	0 510		