Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL407083683M
Compliance #: HL407087069C

Date Concluded: October 13, 2025

Name, Address, and County of Licensee Investigated:
Emalina Cares
2100 55th Avenue North
Brooklyn Center, MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, 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 they failed to provide adequate supervision, resulting in the resident eloping from the facility on more than one occasion. Additionally, the facility failed to initiate preventative interventions after the first elopement.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident had two elopement incidents, the facility made efforts to ensure the resident was safe in the community. The facility respected the resident's rights to go out in the community as he wanted, and notified police when he did not return to the facility as planned. Although the facility lacked documentation of safety interventions and assessments when the resident drank excessive alcohol and went to the emergency room several times, facility staff and the resident's case manager stated the facility had several meetings with the case manager, updated the resident's provider and it was unlikely efforts made would change the resident's alcohol abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a case worker. 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 observed the resident and staff interactions while on site.

The resident resided in an assisted living facility. The resident's diagnoses included alcohol abuse, antisocial personality disorder, and dementia with behavioral disturbance. The resident's service plan included assistance with transfers and mobility. The resident's assessment identified the resident as alert and oriented, and required the use of a wheelchair with staff assistance. The assessment indicated the resident was not at risk for elopement and was at risk to be abused by others.

A facility incident report indicated the resident was reported missing one evening after he did not return to the facility. The report indicated the resident stated he wanted to visit a friend at the barber shop, so facility staff drove him to the barber shop where an agreement was made with the resident that staff would return two hours later to pick him up. The report indicated when staff returned to pick the resident up, he was not there. The staff then observed a metro bus driver assisting the resident off the metro bus. The report indicated staff asked the resident where he went, and the resident stated he went to visit a friend in a different city. The staff drove the resident back to the facility. The resident ate lunch and stated he had to leave again, leaving to the bus stop. The staff called police when the resident did not return to the facility hours later. The report indicated the resident returned to the facility the next day via the metro bus and had a hospital discharge summary with him. The resident was not able to explain how he ended up at the hospital. The report indicated the resident's medical provider and case manager were updated on the incident, and the medical provider gave an order for the resident to see his psychiatrist, and for a motorized scooter so the resident could go in to the community without having to overexert his energy.

A facility incident report, dated approximately three weeks after the previous, indicated the resident was observed wheeling himself to the bus stop around 10:00 a.m. The report indicated the resident was reported missing to the police at 7:00 p.m. when the resident had not returned to the facility. The report indicated staff attempted to call the resident on his phone, but he did not answer it. The report indicated staff contacted local hospitals and shelters in attempt to locate the resident. The report indicated facility staff were informed by hospital emergency room staff the resident had come into the emergency room stating he had escaped from somewhere and reported chest pain. The report indicated emergency room staff reported to facility staff the resident went outside to smoke and the emergency room staff could not locate the resident. The report indicated the resident remained missing at the time of report completion.

The resident's master care plan indicated the resident was independent with transportation and used a metro bus pass. The care plan indicated the resident was not at risk for elopement, and indicated the resident went out a lot and sometimes did not return. The care plan indicated the resident was at risk to be abused by others. The care plan indicated the resident had a history of alcohol abuse disorder and previously declined any type of appointments related to substance abuse. The care plan indicated the facility purchased a cell phone for the resident so they could be in contact with him when he was out in the community, but the resident sold the phone to be able to buy alcohol. The care plan lacked any further documentation of interventions initiated by the facility in attempt to keep the resident safe while out in the community, for alcohol cessation, or for elopement prevention.

The resident's hospital records indicated the resident had 13 emergency room visits over a month and a half period. The hospital records all indicated the resident was assessed and released for alcohol intoxication, altered mental status, and chest pain.

The resident's medical records lacked completed assessments after the resident's hospital visits.

The resident's individual abuse prevention plan (IAPP) lacked documentation to indicate a motorized scooter was in use. The IAPP indicated the resident was not at risk for elopement. The IAPP indicated the resident went in to the community, drank alcohol excessively, and ended up in the emergency room most days that he went out in the community. The IAPP lacked documentation on interventions initiated by the facility in attempt to prevent or decrease these incidents.

The resident's progress notes lacked any follow up assessment on the resident's condition from a nurse after an elopement.

During an interview, an unlicensed personnel (ULP) stated the resident required staff assistance for everything except feeding himself. The ULP stated the resident goes out to the community most days, got drunk, and returned to the facility with aggressive behavior. The ULP stated there were times the resident would go out to smoke but then leave the facility. The ULP stated the resident smoked outside by himself, then used a call light for staff to bring him back in. The ULP stated the resident had a phone they could call him on, but the resident sold it. The ULP stated facility management directed her on what to do every time the resident went out and did not return. The ULP stated they talked to and educated the resident on how it was risky for him to go out and get drunk. The ULP stated they tried their best to keep the resident at the facility, but the resident insisted on going out, and that was his right to do so.

During an interview, a nurse stated the facility had concerns about the resident leaving the facility, and the resident's alcohol intoxication issues. The nurse stated she had attempted to speak to the resident about alcohol treatment, but the resident did not have any interest in it. The nurse stated the resident regularly seen his primary and psychiatric providers who had also

spoke to the resident about alcohol treatment. The nurse stated the resident did not need supervision when outside smoking, and the resident had never eloped while outside smoking, but then stated interventions were initiated after the resident had eloped. The nurse stated the most recent intervention was providing the resident with a life alert emergency response system pendant, so he could press it as needed when out in the community.

During an interview, the licensed assisted living director (LALD) stated the resident was not at risk for elopement; the resident had the right to go out, and the facility cannot do anything about it. The LALD stated he had called police when the resident had not returned to the facility for 24 hours. The LALD stated the resident went out, got drunk, and did not return to the facility. The LALD stated the hospital called him to let him know they had the resident, who was just drunk. The LALD stated he expected the staff to monitor the resident while he was outside smoking. The LALD stated they were not sure how to prevent the resident from going out, because he had spoken to the resident about it and the resident stated it was his right to go out. The LALD stated the facility purchased him a phone to have while out in the community so they could reach him and check on him, but the resident sold it. The LALD stated they updated the resident's providers of his behaviors and have held multiple meetings with the resident's case manager regarding their concerns. The LALD stated the resident now has a scooter and a life alert pendant to use in the community, in hopes to keep him safe while out.

During an interview, the resident's case manager stated he did not have any concerns about the care the resident received at the facility. The case manager stated he has had meetings with the resident and facility staff regarding the concerns of the resident's drinking. The case manager stated the resident had gone out, got drunk, had gotten lost, and had the police called on him. The case manager stated he got the resident a lifeline pendant to take with him to call emergency services if needed so they could locate him. The case manager stated the resident now has a scooter, and the facility wanted to make sure the resident could use it safely. The case manager did not believe the resident could be motivated to reduce his drinking, as the resident does not acknowledge he has a drinking problem. The case manager stated the resident's goal is to be out in the community, and he had that right. The case manager stated the resident was not receptive to additional help getting medical or psychiatric care, or community engagement support. The case manager stated the facility could not physically prevent the resident from leaving the facility, and they provide a good home for him.

During an interview, the resident stated the facility staff treated him well, he was safe at the facility, and he did not have any concerns. The resident stated the facility does not ask him what activities he likes to do, so he goes out to visit his girlfriend two to three times a week. The resident stated he notified staff when he was leaving but did not tell them when he may be back. The resident stated he lost his phone, and he had not spoken to the facility staff about that. The resident stated he intended to return to the facility every time he went out, but there was a time he did not when the battery on his scooter died. The resident denied ever going out and getting drunk, stated he did not have that type of problem. The resident stated there was not anything the facility needed to do to help keep him safe while he was out in the community

as he was good getting around on his own. The resident denied the police had ever been called to assist in locating the resident. The resident stated staff have advised him to not stay out for too long as his scooter battery could die.

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: No, did not return request for interview.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility provided the resident education and alcohol cessation program information, a cell phone, electric scooter, public transportation pass, and life alert system.

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
	40708	A. BUILDING: _____ B. WING _____	C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMALINA CARES LLC	2100 55TH AVE N BROOKLYN CENTER, MN 55430

(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: HL407087069C/HL407083683M On September 9, 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 4 residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL407087069C/HL407083683M, tag identification 630.	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.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40708	A. BUILDING: _____ B. WING _____	C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMALINA CARES LLC	2100 55TH AVE N BROOKLYN CENTER, MN 55430

(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
0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to identify specific interventions for identified self-abuse vulnerabilities, interventions for potential abuse of others and failed to update the individual abuse prevention plan (IAPP), as required for 1 of 1 residents (R1) reviewed. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnosis included alcohol abuse and anti-social disorder. R1's service plan dated March 8, 2025, indicated R1 received assist with dressing, hygiene, toileting, medication	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40708	A. BUILDING: _____ B. WING _____	C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMALINA CARES LLC	2100 55TH AVE N BROOKLYN CENTER, MN 55430

(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
0 630	Continued From page 2 administration, transfers, and mobility. R1's IAPP dated March 31, 2025, indicated R1 required staff assistance with wheeling his wheelchair due to hemiparesis. The IAPP indicated R1 was at risk to be abused by others but was not at risk to abuse others. The IAPP indicated R1 had a history of alcohol abuse disorder but lacked documentation on interventions for this vulnerability. The IAPP indicated R1 had history of agitation, schizophrenia, anxiety and bipolar disorder, but lacked documentation on interventions and behavioral management for the conditions. The IAPP lacked documentation for vulnerabilities related to R1 being a smoker. The IAPP indicated R1 was not at risk for elopement. A facility incident report dated March 28, 2025, indicated staff dropped R1 off at a barbershop to visit a friend and advised R1 they would return two hours later to pick R1 up. The report indicated when the staff returned, staff were unable to find R1. The report indicated staff observed a metro bus staff member assisting R1 from the bus. The report indicated staff returned to the facility with R1, where R1 stated he was going to leave again and went to the bus stop. The report indicated staff reported R1 as missing when R1 did not return to the facility hours later. The report indicated R1 returned to the facility the following day; 18 hours after R1 was reported missing. R1's care plan dated March 31, 2025, inaccurately indicated R1 was not at risk for elopement. The care plan indicated R1 was able to smoke safely, independently, and without intervention. The care plan lacked documentation	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40708	A. BUILDING: _____ B. WING _____	C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMALINA CARES LLC	2100 55TH AVE N BROOKLYN CENTER, MN 55430

(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
0 630	Continued From page 3 on interventions for R1's vulnerabilities. A facility incident report dated April 22, 2025, indicated R1 was observed by staff wheeling himself to the bus stop at 10:00 a.m., on April 21, 2025, and did not return all night. The report indicated staff made several attempts to contact R1 on his phone, but R1 did not answer. The report indicated staff were notified by a hospital emergency room staff that R1 had been there, went outside to smoke, and then could not be found. The report indicated R1 remained missing at the time the report was completed. R1's IAPP dated June 28, 2025, indicated R1 required assist with wheeling his wheelchair due to hemiparesis. The IAPP inaccurately indicated R1 was not an elopement risk, but noted R1 went out a lot and sometimes did not return and had been reported missing twice since admission. The IAPP lacked documentation of interventions for elopement. The IAPP continued to lack interventions for alcohol abuse, mental health and mood disorder interventions and safety interventions for smoking. During an interview on September 12, 2025, at 10:02 a.m., unlicensed personnel (ULP)- A stated R1 went out most days, got drunk, and returned with aggressive demeanor that included insulting the staff, cussing, and yelling. ULP-A stated R1 required assistance from staff to go outside to smoke, would smoke outside by himself, and would use a call light when he was ready to be assisted back inside. ULP-A stated sometimes R1 went outside to smoke and would just be gone. ULP-A stated there was an incident R1 returned to the facility requesting a knife so he could return to the bar and "deal" with a man	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40708	A. BUILDING: _____ B. WING _____	C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMALINA CARES LLC	2100 55TH AVE N BROOKLYN CENTER, MN 55430

(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
0 630	Continued From page 4 there. ULP-A stated the facility knives had to be locked up after that. R1's IAPP lacked identification R1 was at risk to harm others and interventions to prevent R1 from harming others. During an interview on September 17, 2025, at 3:00 p.m., a registered nurse (RN)-B stated she was responsible for completing the resident assessments. RN-B stated an assessment should be completed on a resident after a hospital visit and after an elopement. RN-B stated she was not sure when an IAPP should be updated, that maybe it was yearly. RN-B stated if a resident has vulnerabilities, there should be interventions for them in place. RN-B stated R1 saw his primary care provider and his psychiatric provider and had been offered alcohol abuse treatment, which he declined. RN-B stated the facility obtained a motorized scooter and a life alert pendent for R1 to use while out in the community. RN-B stated R1 could take himself outside to smoke and did not require any supervision while smoking. During an interview on September 18, 2025, at 9:00 a.m., the licensed assisted living director (LALD)-C stated RN-B was responsible for completing resident assessments. LALD-C stated resident IAPP's should include interventions needed to keep a resident safe. LALD-C stated he expected staff to monitor R1 while he was outside smoking. LALD-C stated the facility purchased a phone for R1 and had multiple meetings with R1 and his case manager regarding safety concerns. The licensee-provided policy titled Nursing	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40708	A. BUILDING: _____ B. WING _____	C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMALINA CARES LLC	2100 55TH AVE N BROOKLYN CENTER, MN 55430

(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
0 630	Continued From page 5 Assessment and Reassessment of Residents, undated, indicated the facility will conduct on going reassessment and monitoring as needed based on changes in resident needs. The policy indicated the RN would complete an assessment that included risk indicators such as smoking. The policy indicated an assessment would be completed following a hospital stay and after an adverse event. The policy indicated the RN would update the service plan as needed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		