Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H53241562M **Date Concluded:** March 10, 2023

Name, Address, and County of Licensee Investigated:
The Estates at Bloomington
9200 Nicollet Avenue South
Bloomington, MN 55420
Hennepin County

Facility Type: Nursing Home **Evaluator's Name:** Willette Shafer, 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.

Initial Investigation Allegation(s):
The facility neglected a resident when a confused resident left the facility and was found at a bus stop.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility was not responsible for the maltreatment. The resident had no prior history of leaving or attempting to leave the facility. The resident was found shortly after leaving the facility at a bus stop a block away without injury. The resident retuned to the facility shortly after the incident.

The investigator conducted interviews with facility staff members, including administrative staff and family. The investigator contacted law enforcement. The investigation included review of the resident's medical record including prior incident reports, facility policies, staff schedule, and internal investigation.

The resident resided in a skilled nursing facility. The resident's diagnoses included dementia. The resident's care plan included assistance with meals, redirection, grooming, and bathing. The resident's elopement assessment indicated the resident was not at risk for leaving the facility. The resident scored a three on her Brief Interview for Mental Status indicating the resident had severely impaired cognition.

According to the internal investigation, the resident's care plan was followed at the time of the incident. The resident never attempted to leave the facility in the past. The resident was observed in the lobby at 7:30 a.m. and was unable to be found shortly after. The facility searched the grounds and notified law enforcement. The internal investigation indicated law enforcement found the resident a few feet away at a nearby bus stop. The resident was taken to the hospital for evaluation where no injuries were found. The resident transported back to the facility. The facility completed follow up assessments and implemented interventions to prevent further incidents.

During an interview, a nurse said the resident never attempted to leave the facility in the past. The nurse said according to a recent elopement assessment the resident was not at risk to leave the facility. The nurse said the facility does not have a locked memory care unit and the front door is unlocked. The nurse said he administered medication to the resident in the morning and 30 minutes later they couldn't find the resident for breakfast and started searching the grounds. The nurse said they contacted law enforcement shortly after and law enforcement reported they found the resident at a nearby bus stop. The nurse said the resident was taken to the hospital to be evaluated and shortly after returned to the facility without injury. The nurse said after the incident the facility added new interventions to ensure safety including a wander-guard, re-education for all staff, and a binder at the front desk for the receptionist with photos of residents who are at an increased risk to wander out of the facility.

During an interview, the family member said the resident never tried to leave the facility in the past. The family member said the resident never wore a wander-guard before this incident. The family member said the resident never reported she wanted to leave the facility.

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, due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility implemented a wander-guard intervention for the resident. The facility completed additional training with all staff and posted a binder at the front desk for receptionist with pictures of residents who are at risk for wandering out of the facility.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility 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. You may also call 651-201-4200 to receive a copy via mail or email.

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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
	00169	A. BUILDING: _____ B. WING _____	C 03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT BLOOMINGTON LLC	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H53241562M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		