*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL303424582M
**Compliance #:** HL303425760C

**Date Concluded:** September 9, 2024

**Name, Address, and County of Licensee Investigated:**
Minnesota Greenleaf
1006 Greenwood Street East
Thief River Falls, MN, 56701
Pennington County

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

**Evaluator's Name:** Angela Vatalaro, RN
Special Investigator

**Finding:** Substantiated, facility responsibility

**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 failed to provide supervision. The resident eloped from the locked memory care unit and was found several blocks away.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility staff were unaware the resident had eloped from the locked memory care unit until law enforcement arrived asking if the resident resided at the facility. The resident was found blocks away under a bridge underpass, had an unwitnessed fall, and sustained a left elbow contusion (bruise.)

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of the resident records, hospital record, incident report, law enforcement report, and related facility policy and procedures. Also, the investigator observed the resident and the facility's locked memory care unit.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included safety checks at 7:00 a.m., 10:00 a.m., 1:00 p.m., 3:00 p.m., 7:00 p.m., 9:00 p.m., 11:00 p.m., 1:00 a.m., 4:00 a.m. The resident's assessment indicated the resident wandered hallways and paced during evening time, walked independently, was disoriented to place, time, had moderately impaired decision making, and had no history of elopement.

The resident's record indicated one day staff reported the resident was last observed by staff around 5:30 p.m. during the evening meal. The door alarm went off between 6:00 p.m. and 6:30 p.m., staff checked the doors but did not see anything of concern. Around 7:00 p.m., law enforcement arrived and asked if the facility knew who the resident was. The resident was found blocks away under a bridge underpass. Law enforcement informed the facility the resident was transported to the emergency room.

The law enforcement report indicated law enforcement received multiple calls of a woman passed out in the street under the underpass at 6:31 p.m. and arrived at 6:35 p.m. A passersby assisted the resident off the roadway. When law enforcement arrived, the resident was up on her feet and conscious. The resident was only able to say her last name, told law enforcement she did not know where she was, was from out of town, and was just there visiting. Emergency medical services transported the resident to the hospital.  Law enforcement checked with the facility to see if the resident lived there. Law enforcement was able to identify the resident, learned that she lived at the facility, and spoke to several staff. Staff were unable to provide a definitive answer as to how and when the resident had gotten out of the memory care.

Emergency room records indicated the resident presented to the emergency room after eloping from the facility. The resident was found wandering the streets about two blocks away from the facility. The resident was diagnosed with an unwitnessed fall, a left elbow contusion, and discharged back to the facility.

During an interview, a nurse stated staff last observed the resident at 5:30 p.m. when eating supper. Staff heard a door alarm go off between 6:00 p.m. and 6:30 p.m., staff checked, and did not have any concerns. Staff did not know the resident was missing until law enforcement arrived.

During an interview, leadership stated the resident eloped from the locked memory care unit. The facility was unable to determine what exit door the resident eloped from or how the resident exited. Leadership stated in order to enter or exit the locked unit, a code must be punched into a keypad for each doorway. The memory care unit had a total of three exit doors, one off the facility's lobby, one to an outside patio area, and one at the end of a hallway. All required punching a keycode into a keypad. Leadership stated the main door used to enter and exit memory care was the door located off the facility lobby which also led to the assisted living side of the building. Off the lobby, was an exit door to go outside.  Leadership stated prior to

the resident's elopement, facility staff provided family members and residents who resided on the assisted living side of the building who were also family members, the keycode to enter and exit memory care freely. Leadership stated the facility believed the resident followed behind a family member who passed through the memory care door into the lobby and the resident exited the building. Facility staff were unaware the resident left until law enforcement arrived. Leadership stated any time someone enters or exits the building an alarm sounded. Leadership stated the sound made was a doorbell "ding-dong" type sound and could be heard throughout the entire building. The day the resident eloped; the alarm sounded, and multiple staff checked the facility's lobby door, however, did not see anything of concern. Leadership stated facility staff failed to ensure all the residents in memory care were accounted for following the activation of the door alarm.

During an interview, the resident did not recall eloping from the facility.

During an interview, a family member stated the resident resided in the locked memory unit because of her dementia and risk for leaving the facility.

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

**Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.**
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

**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**: Yes.
**Alleged Perpetrator interviewed**: Not Applicable.

**Action taken by facility:**
The facility increased the resident's safety checks to every one hour, changed all the keycodes for the keypads in memory care, changed their process to only staff knowing the codes, checked memory care window stoppers, posted signage for family and visitors to have escorts by staff to enter and leave the unit, reeducated staff on the varying sounds of door alarms, and reeducated staff how to respond to door alarms including conducting resident head counts.

**Action taken by the Minnesota Department of Health:**
The responsible party will be notified of their right to appeal the maltreatment finding.

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
Pennington County Attorney
Thief River Falls City Attorney
Thief River Falls Police Department

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30342 | A. BUILDING: _____ B. WING _____ | C 08/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MINNESOTA GREENLEAF | 1006 GREENWOOD STREET EAST THIEF RIVER FALLS, MN 56701 |

| (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<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL303425760C/#HL303424582M<br><br>On August 20, 2024, 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 56 residents receiving services under the Assisted Living with Dementia Care license.<br><br>The following correction order is issued for #HL303425760C/#HL303424582M, tag identification 2360. | 0 000 | | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>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. | 02360 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30342 | A. BUILDING: _____ B. WING _____ | C 08/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MINNESOTA GREENLEAF | 1006 GREENWOOD STREET EAST THIEF RIVER FALLS, MN 56701 |

| (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 |
|---|---|---|---|---|
| 02360 | Continued From page 1<br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.<br><br>Findings include:<br><br>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 | | |