Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303424784M
Compliance #: HL303429968C

Date Concluded: August 21, 2025

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: Barbara Axness, 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 staff failed to provide medication management services as ordered. The resident was prescribed a new antibiotic after being hospitalized for a urinary tract infection and the medication was not started timely.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to have a system in place to monitor for missed medication doses, failed to follow up timely on the resident's antibiotic when the medication did not immediately arrive at the facility, and failed to ensure facility staff notified the nurse when medications were not available.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case worker and the primary care provider. The investigation included review of the resident record, personnel files, staff

schedules, and related facility policy and procedures. Also, the investigator observed medication administration at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included dementia and chronic obstructive pulmonary disease (COPD/difficult breathing). The resident's service plan included assistance with medication administration. The resident's assessment indicated facility staff would manage all medications, staff would administer medications, and they would ensure the resident took her ordered medications.

The resident's record indicated the resident was admitted to the hospital with a urinary tract infection (UTI) and kidney infection. The resident returned to the facility two days later with new orders for Cipro, an antibiotic to treat the UTI. A prescriber order indicated the resident was to take the Cipro twice daily for six days. The resident's medication administration record (MAR) indicated the resident did not receive any of the prescribed doses as the medication was not available. Staff entered a note two days after the medication was started which indicated the medication was not in the cart and the director of nursing was notified. The registered nurse (RN) commented she faxed the primary care provider regarding this. A progress note indicated the RN sent a phone message to the primary care provider that the pharmacy did not get the order for Cipro and further instructions were needed. Several doses were marked as not available however there was no documentation to indicate the nurse had been notified. No additional follow up was documented or taken until a state evaluations survey occurred and the state evaluator identified the issue two days later. The resident saw the primary care provider the next day, a Friday, and an order for a new urinalysis was given. The resident wasn't able to provide a urine sample before the clinic closed, so a sample was not sent until Monday. A new order was then written for Cipro twice daily for five days with medication beginning that Monday. The resident's MAR indicated the resident did not receive four doses with staff documenting the medication was not in the cart or was out of stock and that the nurse had been notified. The MAR also indicated the resident was to take the medication for eight days, not the initial five days it was ordered for. The resident's record lacked evidence the RN notified the provider of the additional missed doses.

During an interview, the resident's responsible party stated she had not been told by the facility that the antibiotic wasn't being given and that there usually wasn't great communication from the facility.

During an interview, the resident's primary care provider (PCP) stated she was told by the resident's family she had never received her antibiotic after being hospitalized so she called the facility and looked at the discharge papers and saw the medication was sent to a different pharmacy than what the facility used. The PCP stated it was her assumption no one looked at the discharge papers to see which pharmacy the medication was sent to. The PCP stated she was contacted by the facility a few days after the resident should have started the antibiotic with questions on the antibiotic order and she replied that they would have to contact the

prescriber as she had not initially prescribed the medication. The PCP stated she wasn't sure if the facility had followed up after that.

During investigative interviews, two unlicensed personnel (ULP) stated they had contacted the on-call RN when they noticed the antibiotic was not in stock. The ULP reported the nurse was going to follow up.

During an interview, the facility RN stated she had not been contacted about the antibiotic not being in stock and the on-call nurse did not report any concerns to her. The RN stated at the time the incident happened, she was the only nurse at this facility and the sister facility. The RN stated there was not a system in place to monitor for missed doses of medications in case staff did not notify the nurse of a medication not being available. The RN stated she was struggling to keep up and the facility kept promising they were going to hire someone but it was just her by herself for two buildings and "it was just really hard to keep up with all the responsibilities." The RN stated it was an unfortunate incident with the resident not getting her antibiotic.

During an interview, the on-call RN stated no staff contacted her about the antibiotic being out of stock and if they had, she would have followed up on it.

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

Action taken by facility:
The facility obtained orders to restart the resident on antibiotics. However, additional doses were missed after staff were unable to locate the medication.

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
Minnesota Board of Nursing
Minnesota Board of Executives for Long Term Services and Supports

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 08/05/2025

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 ******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: #HL303424784M/ #HL303429968C On August 5, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 42 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL303424784M/ #HL303429968C tag identification 2360.	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: 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	No plan of correction is required for this tag.	