Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305962880M
Compliance #: HL305962600C

Date Concluded: July 2, 2024

Name, Address, and County of Licensee Investigated:
Garden Court Chateau
2495 SW 8th Street
Grand Rapids, MN 55744
Itasca County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, 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 supervision was not provided in accordance with the resident's plan of care and the resident eloped from the facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. It was unable to be determined whether staff's failure to intervene when the resident was observed ambulating without assistance resulted in the resident's elopement. When staff performed a safety check 20 minutes later, the resident was missing and had eloped from the facility. The resident was located a short time later and sent to the hospital for evaluation. Upon return to the facility, additional interventions were implemented to protect the resident's health and safety.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement. The investigation included review of resident records, facility internal investigation documentation,

facility incident reports, staff schedules, a law enforcement report, and related facility policies and procedures. Also, the investigator observed care and services in the facility.

The resident resided in an assisted living facility. The resident's diagnoses included dementia and macular degeneration. The resident's service plan included assistance with transfers, ambulation, and hourly safety checks. The resident's admission assessment indicated the resident had impaired safety judgement and required a physical assist with one ULP and a gait belt with a walker for transfers and ambulation.

Facility documentation indicated the resident eloped from the facility around 8:38 p.m. The resident was last seen at 8:00 p.m. in the common area and was seen walking in the hall without her walker and stated she was going to bed. When staff went to check on resident at 8:20 p.m. the resident was not in her room. Staff searched the facility and when they were unable to locate the resident, a staff member got in her car and found the resident at a nearby elementary school attempting to find a way inside to get out of the cold. The resident did not have her walker but did have her coat and shoes on. The staff member was able to get the resident into the car and transported her back to the facility. Once back at the facility, staff noted that the resident had multiple injuries including skin tears and documented that the resident hit her head. Emergency services were contacted at 9:05 p.m. and the resident was transported to the emergency room. Administration was notified of the incident.

The resident returned to the facility the next day and nursing staff immediately implemented new interventions to increase supervision of the resident and prevent further occurrence.

During an interview, the facility nurse stated that staff should have immediately intervened when they observed the resident walking independently without a walker, but safety checks were completed per the resident's plan of care. When staff discovered the resident missing, they immediately searched and located the resident, and the resident was sent to the emergency room for further evaluation.

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: Unable due cognitive impairment
Family/Responsible Party interviewed: Attempts to contact were unsuccessful
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

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
	30596	A. BUILDING: _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN COURT CHATEAU	2495 SW 8TH STREET GRAND RAPIDS, MN 55744

(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: #HL305962880M/#HL305962600C On May 30, 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 24 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL305962880M/#HL305962600C, tag identification 0680, 1640.	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.	
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 1 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the missing resident policy was reviewed at least quarterly. This had the potential to affect all residents, staff, and any visitors of the facility. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 680		

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0 680	Continued From page 2 or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Missing Resident policy dated August 1, 2021, lacked documentation the policy had been reviewed quarterly. On June 3, 2024, at licensed assisted living director (LALD)-B was asked how often they review the missing resident plan and stated, "We've always been on the alert for people who are on their way out where they shouldn't be." LALD-B was asked again how often the plan is reviewed and stated, "I don't recall, I think that was during home care license time, I don't recall that was one of the things we had to do. We try if we get more information we try and adjust to it but there's constantly things that are changing it's hard to do that. People forget we're a small group, we're 24 residents it's not very large. To have all these committees and stuff, how do you do that? I'm sorry, but how do you get together larger committees...we're not equipped to do it like this, we're not the size of a nursing home. But we'll be doing it from now on." On June 5, 2024, at 8:05 a.m., clinical nurse supervisor (CNS)-A stated that despite being titled the CNS, she is not able to revise or review policies and does not have any oversight of policies. CNS-A stated facility ownership had responsibility to revise policies. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4, effective October 2022, Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan	0 680		

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0 680	Continued From page 3 at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan was implemented per the resident's assessments for	01640		

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01640	Continued From page 4 one of one resident (R1). The licensee failed to ensure the resident was transferred and ambulated with an assist of one as indicated in the resident's service plan. The resident self transferred and was observed by staff to walk down the hallway independently. Facility staff failed to intervene and the resident eloped from the facility. 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 admitted to the facility on March 18, 2024, at 2:35 p.m. and was noted to be "alert with some confusion." R1's unsigned service plan dated March 19, 2024, indicated the resident received assistance with ambulation, transfers, toileting, dressing, grooming, bathing, and medication administration. R1's admission assessment dated March 18, 2024, indicated the resident required a physical assist with one ULP and a gait belt with a walker for transfers and while walking. The resident had "impaired safety judgment related to cognitive diagnosis." The resident was at risk for elopement/wandering and was noted to be "capable of opening and exiting exterior doors." Staff were to "approach kindly and encourage	01640		

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01640	Continued From page 5 back inside offering a coffee (decaf), bite to eat, especially enjoys sweets-cake, pie, cookies, ice cream. Hourly rounding is GCC's standard safety check for all residents." The resident's family had requested her patio door be blocked so she could not exit through that door. Facility documentation indicated R1 eloped from the facility on March 19, 2024, at 8:38 p.m. The incident report indicated the resident was last seen safe at 8:00 p.m. in the common area and was seen "walking in the hall without her walker and stated she was going to bed. Went to check on resident at 8:20 p.m. and did not see her in her room. Whole facility was checked. Writer went and got in her car and found resident at [elementary school] attempting to find a way inside to get out of the cold. Resident did not have her walker but did have her coat and shoes on. Writer was able to get resident in her personal vehicle and transport her back to the facility. Once back into the facility, writer saw that resident had multiple injuries." Injuries included skin tears and "multiple injuries including hitting of head." 911 was called at 9:05 p.m. and the resident was transported to the emergency room. The LALD was "notified and was made aware of the situation and no advisement given." On June 5, 2024, at 8:05 a.m., clinical nurse supervisor (CNS)-A stated "Upon admission it was readily identified she was a stand by assist" and that staff should have immediately intervened when they observed the resident walking independently without a walker. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		

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