Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307212920M
Compliance #: HL307212714C

Date Concluded: September 11, 2024

Name, Address, and County of Licensee Investigated:
Villa Court
1220 Villa Court Drive
Cromwell, MN 55726
Carlton County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, 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:
The facility neglected the resident when the resident left the building unsupervised, and staff found the resident outside laying on the ground in cold weather.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. When facility staff members noticed the resident was not in her room at the scheduled check, they searched the rest of the facility grounds and found her outside in the parking lot. The resident had left through the front entrance door, the alarm malfunctioned and failed to send an alert to the staff pager. The staff members moved the resident inside and was evaluated by emergency services.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record,

facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed the door entrance area, the general layout of the facility and spoke with other residents who lived at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included a history of stroke, dementia, back pain related to compression fractures and a history of falls. The resident's service plan included assistance with all activities of daily living. The resident's assessment indicated she was at risk for falls, used a walker, a wheelchair and had back pain that limited her mobility. The assessment indicated the resident had confusion but was not at risk for wandering outside the facility.

The facility incident report indicated staff members began searching for the resident when the resident was not in her room at bed check time. The report indicated staff members found the resident outside lying on the ground and they brought her inside to warm her up. The resident did not know where she was or where she had been.

During an interview, a staff member stated staff members located the resident in the parking lot where she had fallen on the ground. The resident was immediately brought in, vital signs were taken, she was cold, and her lips were blue. The nurse and emergency services were contacted.

During staff interviews, multiple staff members stated the door alarm, which was supposed to send an alert when the entrance door was opened after hours, had not worked that night.

During interview, the nurse stated the doors alarm system was not working that night and the company could not fix the issue until a few days later. Once this issue was identified, the facility completed 30-minute resident checks, and a temporary tab alarm was placed on the entrance door. The nurse stated the resident suffered frost bite but no long term injury. She stated the resident did not have a history of leaving the building alone and typically did not walk that far due to her back pain. The nurse stated the resident was looking for her husband earlier in the day and thought he was out in the parking lot and must have left the building between last evening rounds and first night rounds, which would have been in a two hour time span.

The resident was interviewed at the time of the facility visit and could not remember the details of the event.

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: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility took steps to mitigate the risk of the malfunctioned door alarm until it could be fixed.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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
	30721	A. BUILDING: _____ B. WING _____	C 08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA VISTA AND CARDINAL COURT	1220 VILLA COURT DRIVE CROMWELL, MN 55726

(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 On August 8, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL307212714C/#HL307212920M. No correction orders are issued.	0 000		