Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL334479662M
Compliance #: HL334473981C

Date Concluded: April 10, 2026

Name, Address, and County of Licensee Investigated:
Ashby Living Center
112 Iverson Avenue
Ashby, MN 56309
Grant 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 supervision for a resident with cognitive impairment. The resident cut off his wander guard (a bracelet designed to prevent him from leaving the building) eloped from the facility and fell. The resident was evaluated in the emergency room for a neck fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to assess and implement interventions related to the resident's risk for elopement. The resident eloped from the facility. The resident fell and was found outside a local business by a community member who contacted 911. The resident was sent to the hospital and diagnosed with a neck fracture. Upon return to the facility, nursing staff failed to implement additional interventions to prevent further elopements.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record, hospital records, facility internal investigation documentation, facility incident reports, staff schedules, an ambulance report, and related facility policy and procedures. Also, the investigator observed the facility environment and exit doors at the time of the onsite investigation.

The resident resided in an assisted living with dementia care facility; however, the facility did not have a locked memory care unit. The facility had three exit doors that were accessible to residents, however only two of the doors were secured with a wander guard system (an automatic door lock that would cause the exit doors to lock if a resident wearing a wander guard bracelet approached the door.)

The resident's diagnoses included Alzheimer's disease. The resident's unsigned service plan included assistance with managing wandering and elopement threat. The resident's assessment indicated the resident was at risk for elopement. Interventions included a wander guard to his walker and Quetiapine (antipsychotic medication) 25 milligrams twice daily. The resident was noted to use his walker at times to assist with walking.

The resident's service plan did not include a service to check placement or location of the wander guard. The resident's assessment did not include assessment of the resident's risk for falls.

Approximately one week after admission to the facility, staff documented the resident cut off his wander guard from his ankle. The resident refused to have it placed back on his ankle, so staff placed it on his walker. Approximately one month later, the resident eloped from the facility. The resident was found by a community member who called 911 and was the first to notify facility staff of the resident's whereabouts. The resident was taken to the hospital.

Hospital records indicated the resident eloped from the facility and was found on the ground outside. The resident had a laceration to his forehead and abrasions on his nose, forehead and hands. The resident was also diagnosed with a fracture in his neck and returned to the facility with orders to wear a cervical collar for six weeks.

Following the resident's elopement and return to the facility, a change in condition assessment was not completed. A progress note indicated the RN assessed the resident and implemented a bed and chair alarm as a fall prevention measure. There was no documentation of an assessment of the resident's wander guard or evaluation of additional elopement interventions. Documentation from the facility indicated the resident again cut off his wander guard after returning to the facility.

During an interview, the licensed practical nurse (LPN) stated she completed all the resident's assessments, but a registered nurse reviewed them. The LPN stated she did not believe staff

were checking that the wander guard was on the resident or that it was working at the time he eloped. The LPN confirmed the assessment failed to address the resident's history of removing his wander guard and that the wander guard remained as an elopement intervention. The LPN stated the resident was wanting to cut off his wander guard so they moved his room closer to the main area so they could keep a better eye on him.

During an interview, ULP #1 stated she was working the day the resident eloped. ULP #1 stated there had been a couple of instances where he had cut his wander guard off, so the device was placed on his walker instead of on him. ULP #1 stated at the time of the elopement, it was not part of the resident's service plan to make sure the wander guard was intact and in place. ULP #1 stated the resident left a door that was near his room and staff were not aware that he had left until someone called the facility saying they had found him outside and he was going to a nearby hospital.

During an interview, ULP #2 stated she was working the day the resident eloped. ULP #2 stated the resident did not take his walker when he eloped from the building and the wander guard was on his walker. ULP #2 stated the resident required reminders to use his walker and would not always use it. ULP #2 stated the resident had cut off his wander guard previously. ULP #2 stated they did not know the resident was missing until someone had called the facility and said he fell by a business in town.

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 investigated the elopement and reported it to MAARC.

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
Grant County Attorney
Ashby City Attorney
Ashby Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33447	A. BUILDING: _____ B. WING _____	C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBY LIVING CENTER	112 IVERSON AVENUE ASHBY, MN 56309

(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: #HL334479662M/#HL334473981C On February 5, 2026, 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 18 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL334479662M/#HL334473981C, tag identification 1610, 1620, 2310, 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.	
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring	01610		

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01610	Continued From page 1 (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an initial nursing assessment was completed by a Registered Nurse for one of one (R1) residents with records reviewed. 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 November 10, 2025.	01610		

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01610	Continued From page 2 On February 5, 2026, R1's admission assessment was requested. An assessment titled admission assessment completed by licensed practical nurse (LPN)-B dated December 17, 2025, was provided. On February 6, 2026, at 12:01 p.m., licensed assisted living director (LALD)-A confirmed an admission assessment was done upon move in by LPN-B and reviewed by a registered nurse (RN). On February 9, 2026, at 8:54 a.m., LALD-A wrote that a RN completed an admission assessment on paper but the paper assessment was lost. The licensee's Resident Pre-Admission Assessment & Monitoring Process policy indicated all residents moving into an assisted living would be offered a pre-admission assessment by a registered nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident	01620		

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01620	Continued From page 3 executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective	01620		

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01620	Continued From page 4 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an ongoing resident reassessment to include all areas required on the uniform assessment tool for one of one resident (R1) with record reviewed. 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 eloped from the facility and was evaluated in the emergency room on January 9, 2026. R1 returned to the facility with a new diagnosis of a C2 odontoid fracture (neck fracture) and orders to wear a cervical collar at all times for six weeks. R1's record lacked a change in condition assessment. R1's record contained a progress note titled Post-Hospitalization Nursing Assessment dated January 10, 2026. The progress note lacked the following areas required on the uniform assessment tool: -the resident's personal lifestyle preferences, including: -sleep schedule, dietary and social needs, leisure	01620		

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01620	Continued From page 5 activities, and any other customary routine that is important to the resident's quality of life; -spiritual and cultural preferences; and -advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" or "physician/provider orders for life-sustaining treatment" order; -activities of daily living, including: -toileting pattern, bowel, and bladder control; -dressing, grooming, bathing, and personal hygiene; -mobility, including ambulation, transfers, and assistive devices; and -eating, dental status, oral care, and assistive devices and dentures, if applicable; -instrumental activities of daily living, including: -ability to self manage medications; - housework and laundry; and -transportation; -physical health status, including: -allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening; -a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a postacute care facility; -a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months; -weight -emotional and mental health conditions, including: -review of history of and any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral disorders; -current symptoms of mental health conditions and behavioral expressions of concerns; and	01620		

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01620	Continued From page 6 -effective medication treatment and nonmedication interventions; -cognition, including: a review of any neurocognitive evaluations and diagnoses; and assistive communication and sensory devices including hearing aids; and the ability to understand and be understood; -pain, including: location, frequency, intensity, and duration; and effectiveness of medication and nonmedication alternatives; -nutritional and hydration status and preferences; -list of treatments, including type, frequency, and level of assistance needed; -nursing needs, including potential to receive nursing-delegated services; -risk indicators, including: risk for falls including history of falls; emergency evacuation ability; complex medication regimen; -risk for dehydration, including history of urinary tract infections and current fluid intake pattern; -risk for emotional or psychological distress due to personal losses; -unsuccessful prior placements; -elopement risk including history or previous elopements; -smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and -alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; -who has decision-making authority for the resident, including: the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and the scope of decision-making authority of a substitute decision maker under subitem On February licensed assisted living director (LALD)-A stated the facility was using a nurse	01620		

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01620	Continued From page 7 consultant as the interim clinical nurse supervisor at the time of the elopement. LALD-A stated the consultant RN had sent them an email of all the things that needed to be included on the post-hospitalization assessment so the facility RN entered it as a progress note, covering all the topics they were told to cover by the nurse consultant. LALD-A stated she was not sure why they were not directed to use the assessment template in the facility's electronic medical record. On February 10, 2026, at 1:35 p.m., registered nurse (RN)-F stated she had completed the January 10, 2026, progress note at the direction of the nurse consultant. RN-F stated she mostly worked as a lead caregiver. RN-F stated she was not previously aware of R1's history of removing his wander guard. RN-F stated after R1's elopement, she recommended his wander guard be placed on his shoe. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure care and services were	02310		

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02310	Continued From page 8 provided according to acceptable health care and medical, or nursing standards for one of one residents (R1) who was at risk for elopement. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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: The facility was licensed as an assisted living with dementia care facility but did not have a locked memory care unit. The facility had three exit doors that were accessible to residents, however only two of the doors were secured with a wander guard system (an automatic door lock that would cause the exit doors to lock if a resident wearing a wander guard bracelet approached the door.) R1's diagnoses included Alzheimer's disease. R1 admitted to the facility on November 11, 2025. R1's record lacked an admission assessment completed at the time of admission to the facility. The licensee's dementia disclosure form indicated for residents whose wandering at times leads them out of the building unsupervised, the facility had a security system to help minimize risk to them. It was noted a sensor bracelet could be placed on the person and that would trigger an alarm if they walked through an unattended exit. If a resident requiring the device found ways to remove it, the facility could "creatively try other	02310		

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02310	Continued From page 9 placements" of the sensor such as a walker or shoe which the resident used all the time. The device was noted to be effective for most people who wander aimlessly. A paragraph for wandering limitation read, "The approaches listed above are typically ineffective in safeguarding a person who is exit-seeking. For that reason, Ashby Living Center is not an appropriate placement for such an individual." R1's unsigned service plan indicated the resident received assistance with managing wandering and elopement threat. Progress notes indicated on November 18, 2025, the resident removed his wander guard from his ankle. Staff tried to put it back on but he refused. The wander guard was then placed on his walker. The RN failed to implement interventions to ensure the wander guard remained in place. R1's assessment dated November 28, 2025, indicated the resident was at risk of elopement and had a history of saying he wanted to walk to Elbow Lake or home. Interventions included a wander guard to his walker and twice daily Quetiapine 25 milligrams (mg). The resident was also noted to wander in the common areas. The resident was independent with ambulation and was noted to use a walker at times. The assessment did not mention R1's history of removing his wander guard. R1's service recap summary for January 2026 indicated R1 did not have scheduled safety checks and did not have instructions for the staff to ensure R1's wander guard was in place and had not been removed. R1 had a service once per shift to manage his wandering.	02310		

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02310	Continued From page 10 An incident report dated January 9, 2026, indicated the resident was reported missing at 8:20 a.m. when a community member reported to staff that the resident had fallen outside their business and sustained a head laceration and they had called emergency services. Actions to prevent elopement from occurring again indicated R1 was issued a wander guard upon admission to wear on his wrist but he cut it off and was "defiant" about wearing it. It was noted the resident had not left the building without staff assistance. After a review, the wander guard was attached to R1's walker. After the elopement, the wander guard was placed on his ankle and was told it was counting his steps. The service plan was updated to include hourly checks and to ensure the wander guard was in place. The door system was to be upgraded to include a locking mechanism when a resident with a wander guard approached the door. Hospital records indicated the resident eloped from his assisted living and was found on the ground outside on January 9, 2026. The resident had a laceration to his forehead, abrasions on his nose and forehead and hands. The resident was diagnosed with a fracture in his neck and returned to the facility with orders to wear a cervical collar for six weeks. After R1 returned to the facility, a change in condition assessment was not completed. A progress note titled Post-Hospitalization Nursing Assessment was entered which failed to cover all the required topics of the Uniform Assessment Tool. The progress note failed to identify R1 had recently eloped. One hour safety checks were added to ensure the resident was wearing his cervical collar. A chair and bed alarm were recommended for fall prevention. It was noted R1	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33447	A. BUILDING: _____ B. WING _____	C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 11 walks away from his walker. The progress note failed to identify any new interventions related to R1's recent elopement or wander guard use. On February 10, 2026, at 11:05 a.m., unlicensed personnel (ULP)-C stated she was working the day the resident eloped. ULP-C stated there had been a couple of instances where he had cut his wander guard off so the device was placed on his walker instead. ULP-C stated at the time of the elopement, it was not part of the resident's service plan to make sure the wander guard was intact and in place. ULP-C stated the resident had left out of a door that was near his room staff were not aware that he had left until someone called the facility saying they had found him outside and he was going to a nearby hospital. On February 10, 2026, at 11:20 a.m., ULP-D stated she was working the day the resident eloped. ULP-D stated the resident did not take his walker when he eloped from the building and the wander guard was on his walker. ULP-D stated the resident required reminders to use his walker and would not always use it. ULP-D stated the resident had cut off his wander guard previously. ULP-D stated they did not know the resident was missing until someone had called the facility and said he fell by a business in town. On February 10, 2026, at 1:35 p.m., registered nurse (RN)-F stated she had completed the January 10, 2026, progress note at the direction of the nurse consultant. RN-F stated she mostly worked as a lead caregiver. RN-F stated she was not previously aware of R1's history of removing his wander guard. RN-F stated after R1's elopement, she recommended his wander guard be placed on his shoe.	02310		

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02310	Continued From page 12 On February 10, 2026, licensed practical nurse (LPN)-B stated she had completed some assessments on R1 while the facility was in between permanent registered nurses (RNs). LPN-B stated the interim RN would review and sign off on any assessment she completed to ensure accuracy. LPN-B stated R1 was wanting to cut off the wander guard when it was on his body so they moved his room closer to the common area and put the wander guard on his walker. LPN-B confirmed the assessment failed to include R1's history of removing his wander guard and there were no checks implemented to ensure the resident's wander guard was in place and no routine safety checks prior to the resident's January 9th elopement. LPN-B confirmed staff were likely not checking R1 was wearing a wander guard and verifying it was working at the time of his elopement. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment 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. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. Findings include:	02360	No plan of correction is required for this tag.	

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02360	Continued From page 13 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		