Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303428142M
Compliance #: HL303424361C

Date Concluded: March 25, 2025

Name, Address, and County of Licensee Investigated:
Minnesota Greenleaf
3006 Greenwood Street
Thief River Falls, MN 56701
Pennington County

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

Evaluator's Name: Christine Bluhm, 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: The alleged perpetrator (AP) abused the resident which resulted in a purple bruise on the resident's left breast. The resident displayed a change in behavior by isolating more to her room and flinched during personal cares during that time.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was inconclusive. While there is sufficient evidence showing the resident's left breast was bruised, there is not sufficient evidence to demonstrate how it occurred nor who might be responsible.

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, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. The investigator observed interactions between staff and residents during a recent visit to the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's Disease. The resident's service plan included assistance with activities of living including personal cares and bathing assistance. The resident's assessment indicated she could ambulate on her own, had poor memory and impaired decision-making skills.

One morning caregivers noticed the resident had discoloration located on her left breast, which had characteristics of a new bruise. Caregivers also observed the resident flinch when approached during bathing cares and isolated herself more to her room when her routine had been to walk in the hallways.

A facility incident report indicated staff members identified a bruise on the resident's left breast with morning cares and notified the on-call nurse.

A progress note later the same day indicated the bruise presented as a purple coloration on her skin. When unlicensed caregivers attempted to assist her with a shower, noticed the discoloration, and asked the resident what occurred. The same document indicated the resident said a [reference to skin color] "did it".

The medical record indicated the bruise resolved without treatment.

During an interview, a nurse stated that she did not interview the resident but received the information from caregivers who assisted the resident that day. The nurse stated staff members schedules were reviewed to narrow down the staff who worked when the injury may have occurred.

During an interview, an unlicensed caregiver stated the resident was jumpy and seemed to resist physical touch during shower assistance one morning. The caregiver stated she noticed the bruise, which was not there the day before. The caregiver stated that the resident said 'the [reference to skin color] girl did it.' The caregiver stated there were multiple females working at the facility who fit that description worked at the facility along with the AP, however the AP had worked the night before the bruise was identified.

During interview, a manager stated that the injury looked like a pinch bruise.

During interview with this investigator, the resident had difficulty recalling person, place and time questions and was unable to recall any incident in which the bruise could have occurred.

During interview, a family member stated he was not aware of the bruise found on the resident or had he heard there was an allegation of any suspected abuse.

The Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, the AP declined an interview with the investigator.

Action taken by facility: The facility reported the matter to law enforcement. The AP no longer works at the facility.

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
	30342	A. BUILDING: _____ B. WING _____	C 03/06/2025

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 On March 6, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL303425200C/#HL303428422M and HL303424361C/#HL303428142M. No correction orders are issued.	0 000		