Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306019766M
Compliance #: HL306017711C

Date Concluded: February 5, 2024

Name, Address, and County of Licensee Investigated:
Summit Ridge Place
1325 Summit Ave N
Sauk Rapids, MN 56379
Benton County

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

Evaluator's Name: Carrie Euerle MSN, 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 they failed to provide supervision in accordance with the resident's service plan 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 complete a safety check at the scheduled time resulted in the resident's elopement, and the actions the resident took to carry out the elopement could not be predicted. When staff discovered the resident missing, staff immediately contacted the police, the resident's guardian, and facility administration. The resident was located a short time later and sent to the hospital for evaluation. The resident sustained no injuries and upon his 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 the resident's family. The investigation included review of the resident's medical record, hospital records, facility internal investigation documentation, personnel files, staffing schedules, law enforcement reports, and facility policies and procedures.

The resident resided in an assisted living memory care unit. The resident's diagnoses included delirium and cognitive impairment. The resident's assessment identified the resident as alert and oriented to person, place, and time, with a history of poor decision making. The resident's assessment identified the resident as a high elopement risk due to being upset with placement in a memory care unit. The resident's service plan included assistance with activities of daily living, medication management, behavior monitoring, and every two-hour safety checks.

A facility report indicated the resident eloped out of the window of his room from the locked memory care unit.

Around 9:00 p.m. on the night of the elopement, the resident informed an evening shift staff member he was leaving for the weekend and requested his medication. The staff member told the resident he could not leave the facility unsupervised or without the permission of his guardian, which upset the resident. The resident told the staff member that he planned on leaving "no matter what" then went to his room.

The evening shift staff member later documented she completed a final evening shift safety check on the resident at 10:12 p.m. The staff member documented the safety check was completed from outside of the door, due to the resident being upset, and she heard the resident "throwing and banging things around his room".

The night shift began at 10:30 p.m. The evening shift staff member informed night shift staff that the resident was upset after not being allowed to leave earlier that evening and reminded them to complete safety checks on the resident.

The resident's next scheduled safety check was scheduled for 12:00 a.m., however, the safety check was not completed until sometime after 1:00 a.m.

Facility documentation indicated night shift staff completed a safety check on the resident sometime between 1:15 and 1:51 a.m. When staff arrived at the resident's room, the door was locked. Staff located a master key to open the door, but the resident was not in the room; the window was open, and the screen had been removed. Staff contacted the on-call nurse, police, and facility administration after they discovered the resident missing.

A police report indicated police were contacted at 1:52 a.m. and arrived at the facility around 1:59 a.m. Shortly after police arrived, the resident was located at his previous home address and transported to the hospital for further evaluation.

The resident was evaluated at the hospital and returned to the facility the next day. Prior to the resident's return, the facility secured the resident's window and updated the service plan to include more frequent safety checks.

During an interview, the evening shift staff member stated the resident was upset with her, so she did not enter the resident's room to visualize the resident for her last safety check. The staff member recalled the resident telling her, "I'm leaving, no matter what; if I have to go out the window, I'm leaving." The staff member said she did not think the resident could or would have the ability to escape out of the window. The staff member acknowledged she should have opened the door to complete the safety check but didn't want to escalate the situation at the time.

Night shift staff stated they did not check on the resident at the beginning of their shift because a safety check was just completed by evening shift staff. Night shift staff stated they completed routine cleaning tasks before starting resident rounds and safety checks. Night shift staff stated the safety check was not completed at 12:00 a.m. as they started resident rounds on the other side of the building. However, when they got to the resident's room during their rounds and discovered the resident missing, they immediately contacted the on-call nurse, police, and facility administration.

During an interview, facility administration stated the resident admitted to the facility one week prior to the elopement. Administration indicated they were aware of the resident's risk for elopement but indicated the resident had no elopement attempts or exit-seeking behavior prior to this incident. Following the incident, administration indicated new interventions were implemented to ensure the resident's safety and all staff were re-educated on safety checks, documentation, and resident supervision.

During an interview with the resident's family, the family indicated they were informed of the elopement by the facility and the police at the time of the incident. The family described the incident as a set of unfortunate circumstances; however, they had no concerns with the care provided by the facility.

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: No; Attempts to contact were unsuccessful.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility contacted police when the resident was discovered missing. Following the incident, the facility installed locks and alarms on the resident’s window and increased their supervision of the resident.

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
	30601	A. BUILDING: _____ B. WING _____	C 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

(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 December 13, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL306017711C/HL306019766M. No correction orders are issued.	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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	