Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL371045262M
Compliance #: HL371041942C

Date Concluded: November 5, 2025

Name, Address, and County of Licensee Investigated:
Greatercare Facilities LLC
2087 Woodbridge Way
Woodbury, MN, 55125
Washington County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, 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(s):
The facility staff neglected the resident when staff failed to provide the resident adeqate supervison. As a result, the resident was found lying face down on the floor with vomit and difficulty breathing. The resident required intubation and transported to the hosptial. Two bottles of vodka were found in the resident's room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident was free to come and go into the community unsupervised. The resident had alcohol dependency, and the facility had interventions in place. The day of the incident, staff had seen the resident out of his room in the communal spaces within an hour of the incident. Staff did not observe any abnormal behavior nor were staff aware the resident had alcohol/liquor in his room. When staff found the resident lying face down in his room, throwing up, and struggling to breath, staff called emergency medical services (EMS).

The investigator conducted interviews with facility staff members including administrative and nursing staff. The investigator contacted the resident's case manager. The investigation included review of the resident records, hospital records, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed staff conduct a safety check on the resident and staff interactions with the resident.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia, alcohol use disorder and dependency. The resident's service plan included assistance with safety checks every hour. The resident's assessment indicated the resident had multiple previous episodes of intoxication with alcohol. Interventions included staff monitoring of the resident for unsafe alcohol use including intoxication including scanning his environment during safety checks. If noted of alcohol use, staff were to call 911, the nurse, management, and conduct safety checks on the resident every 30 minutes to ensure safety and wellbeing. Staff were to encourage the resident to remain sober. The resident was oriented to person, place, and time. The resident walked independently.

The resident's record indicated two previous incidents related to alcohol use. Both incident's staff contacted EMS, and the nurse. On both occasions, the resident transported to the hospital and returned the same day. The incident reports indicated the resident's case management team was updated. An incident report also indicated the resident's mental health provider was updated.

Three months after that, a third incident report indicated the resident was found lying on his stomach in his room, throwing up, and struggling to breath during a staff safety check. The incident report indicated staff immediately called 911 and followed instructions of the dispatcher to lay the resident sideways. Staff found a 750 milliliter empty bottle of vodka, 40% alcohol content, in the resident's trash bin as well as another almost empty bottle of vodka on top of the resident's dresser. The resident's assessment indicated the resident was sent to the hospital, required intubation (tube inserted into the airway to assist with breathing), later extubated (removal of tube) and discharged.

The resident's scheduled services record and progress notes indicated the resident received safety checks.

The resident's hospital records indicated the resident was found unresponsive on the floor in his room. The facility staff said they did not hear the resident fall. The facility staff reported they had last seen the resident 50 minutes prior, and at that time the resident was well.

The resident's hospital discharge records indicated the resident admitted to the hospital with alcohol withdrawal and received antibiotic treatment for aspiration pneumonia (caused by inhaling something other than air into the lungs.) Progress notes indicated two days later; the resident discharged back to the facility.

After the hospitalization, the resident's assessment indicated staff were monitor the resident closely for unsafe alcohol use. Staff were to perform safety checks every 30 minutes to one hour to ensure the resident's safety and wellbeing.

The resident's summary from a clinic visit indicated the resident was seen for a follow-up by his medical provider related to his hospitalization and alcohol use disorder.

During onsite compliance interviews, multiple unlicensed staff members stated the resident received a safety check every hour.

Five months of progress notes were reviewed. Staff documented safety checks were conducted on shift notes. During the five months, the three occasions staff found the resident "passed out" related to alcohol use; all three occasions staff called EMS. All three occasions also had corelating incident reports which identified if alcohol/liquor bottles were found by staff. The progress notes did not indicate any other occasions when staff found alcohol/liquor bottles or indicate any other occasions of staff finding the resident passed out related to alcohol use.

During an interview, a case manager stated a safety plan was developed with the resident, facility, and the resident's support team related to alcohol use. The plan was during safety checks, staff scan the resident's room for any observable alcohol/liquor bottles, check for alcohol use, and check for any alcohol related odor. If there were any concerns of alcohol use, or any bags of items being brought in by the resident from the community, the resident's safety checks increased to every 15 to 30 minutes. Otherwise, the resident was checked on every hour. The resident was able to go into the community unsupervised. The case manager stated the facility notified her when the resident was hospitalized. Since the incident, the facility had not notified her of any further incidents related to the resident's alcohol use.

During an interview, a nurse stated the resident received safety checks due to his vulnerability and risk of alcohol abuse. If the resident was found with alcohol, showed any behaviors of alcohol use and/or intoxication, staff were trained to notify the nurse. The resident was able to go into the community unsupervised. If the resident returned with any bags of items and staff had any suspicions of alcohol, the nurse said staff become more vigilant with their safety checks and increased monitoring. Staff observed the resident's environment during the checks and looked for any signs of alcohol use. If observed, staff contacted the nurse. If the resident was ever found unresponsive or if it was an emergency, staff called 911. The nurse said there was incident when the resident was hospitalized. The resident was intubated, later extubated, and returned to the facility. The nurse stated that day, prior to staff finding the resident on the floor in his room, staff had recently observed the resident within 30 minutes to an hour. Staff observed the resident exit his room, walk to communal spaces, and observed the resident reenter his room. The nurse said staff did not observe any abnormal behavior. During a routine safety check, staff found the resident on the floor in his room. Staff contacted the nurse and called EMS. The nurse said prior to the incident, staff did not know the resident had any alcohol/liquor in his room nor did the resident show any abnormal behaviors. The nurse stated

before and after this incident the nurse had spoken to the resident about his alcohol use and educated the resident on the risks. Staff monitored the resident for alcohol use and conducted safety checks. The nurse stated since the resident's hospitalization, the resident's alcohol use was almost non-existent. Facility staff had not found any further alcohol/liquor bottles in the resident's room.

During an interview, the resident stated the facility staff checked in on him to see if he was okay. The resident stated he "probably" was hospitalized related to alcohol use but did not remember the incident. The resident stated he felt safe at the facility and did not have any concerns with staff checking in on him related to his alcohol use.

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: No. Responsible for self.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
When staff found the resident lying on his stomach in his room, throwing up, and struggling to breath, staff called 911. The facility had alcohol monitoring and interventions in place.

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
	37104	A. BUILDING: _____ B. WING _____	C 10/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREATERCARE FACILITIES LLC	2087 WOODBRIDGE WAY WOODBURY, MN 55125

(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 October 27, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL371041942C/#HL371045262M. No correction orders are issued.	0 000		