

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202572843M
Compliance #: HL202571179C

Date Concluded: June 11, 2026

Name, Address, and County of Licensee

Investigated:

North Ridge Assisted Living
5500 Boone Ave N
New Hope, MN, 55428
Hennepin County

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

Evaluator's Name: Lacey Eggersdorfer, RN
Special Investigator
Brooke Anderson 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 alleged perpetrator (AP) abused resident 1 and resident 2 when the alleged perpetrator grabbed resident 1 during toileting and grabbed resident 2 during showering. Resident 1 obtained bruising to the left wrist and forearm and resident 2 obtained bruising to both left and right forearm.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was not substantiated. Although the residents sustained bruising on their arms during personal cares. There was no evidence to support the bruises were the result of abuse.

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

facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures.

Resident 1 resided in an assisted living memory care unit. Her diagnoses included Alzheimer's. Resident 1's service plan included assistance with activities of daily living such as dressing and toileting, and assistance with transferring. Resident 1's assessment indicated she had severe cognitive impairment and resident 1 was risk for skin breakdown related to decreased subcutaneous tissue.

Resident 2 resided in an assisted living memory care unit. Resident 2's diagnoses included dementia. Resident 2's service plan included assistance with activities of daily living such as showering. Resident 2's assessment indicated he had severe cognitive impairment.

An incident report indicated resident 1 was found to have a bruise to the left wrist. The report indicated the bruise was shaped as a handprint. The resident was unable to say how it happened.

Another incident report indicated resident 2 had a bruise to his left wrist and forearm. Resident 2 indicated in the report that it was from staff twisting and pulling.

Facility documents indicated unlicensed staff reported bruising noted on resident 1's left wrist and resident 2 had bruising on his left wrist and forearm. Nursing staff assessed the residents. When investigating the bruising unlicensed staff 1 and 2 reported concerns with the AP's care of the residents. The facility documents indicated the AP denied causing any bruising and denied excessive force while providing care for the residents.

During an interview, unlicensed staff 1 stated the AP picked up a shift in an area she usually didn't work. Unlicensed 1 stated she went into resident 1's bathroom and saw the AP grabbing resident 1 by the wrist while putting the resident's shirt on. Unlicensed staff 1 stated resident 1 said ouch you are hurting me and unlicensed staff told the AP to leave the bathroom. The AP left the bathroom and unlicensed staff 2 assisted the resident to shower and get dressed.

During an interview, unlicensed staff 2 stated the AP usually didn't work with resident 2. Resident 2 was scheduled to receive help with a shower. The AP went in and started to attempt to give resident 2 a shower when unlicensed staff 2 entered the room the AP was holding onto resident 2's arms. The AP told unlicensed staff that resident 2 had slapped her. Unlicensed staff 2 stated she removed the AP's hands from resident 2 and finished resident 2's shower.

During an interview, resident 1 stated staff had never hurt her and she had no concerns.

During an interview, resident 2 stated he did get a bruise from "man handling" but he could not recall when the bruising occurred or who gave him the bruise.

During an interview, the nurse stated she was asked to investigate the bruise on the wrist of resident 1. She stated that she spoke with facility staff who were working and found unlicensed staff 2 had concerns about how the AP handled resident 1, the AP grabbed resident 1's wrist while assisting her up from toileting four days prior. When interviewed unlicensed staff 1 and 2 denied witnessing the AP grabbing resident 2 but reported resident 2 was upset with the AP. The nurse stated both residents were assessed and bruising was noted. The nurse stated the AP was interviewed during the facility investigation and stated just because unlicensed staff reported the residents were abused doesn't mean abuse occurred.

During an interview with a family member of resident 1, they stated they were aware of the bruising and concerned about a staff member being rough with resident 1.

During an interview with a family member of resident 2, they stated they were aware of an incident but did not have any concerns and were happy with the care he was receiving.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.

"Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;

(2) the use of drugs to injure or facilitate crime as defined in section 609.235;

(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and

(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(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 Adults interviewed: Yes

Family/Responsible Parties interviewed: Yes

Alleged Perpetrator interviewed: No, multiple attempts to reach the alleged perpetrator failed.

Action taken by facility:

The facility internally investigated and terminated the alleged perpetrator.

Action Taken by the Minnesota Department of Health:

No further action taken at this time.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20257	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/18/2026
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NAME OF PROVIDER OR SUPPLIER ASSISTED LIVING AT NORTH RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 5500 BOONE AVENUE NORTH NEW HOPE, MN 55428
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(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	<p>Initial Comments</p> <p>On 5/18/26, the Minnesota Department of Health initiated an investigation of complaint #HL202572370C, and #HL202571179C/#HL202572843M. . No correction orders are issued.</p>	0 000		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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