Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202573243M
Compliance #: HL202576168C

Date Concluded: August 25, 2025

Name, Address, and County of Licensee Investigated:
Assisted Living at North Ridge
5500 Boone Avenue North
New Hope, MN 55428
Hennepin County

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

Evaluator's Name: Willette Shafer, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:
The Minnesota Department of Health investigated an allegati0on 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 unknown alleged perpetrator (AP) and facility neglected the resident when the AP failed to report a fall with injury and the facility failed to provide medical care after learning of the fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident was unable to state what night the alleged incident occurred and did not report the fall to staff. The resident reported the fall to a family member who then reported the incident to the nurse. Once the facility learned of the fall, the facility assessed the resident, reported the incident to a provider, and ordered an x-ray. The x-ray indicated no fracture, and the resident returned to baseline.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The

investigation included review of the resident's record, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator toured the facility and observed care provided to the residents and the response time to pendent alerts.

The resident resided in an assisted living facility. The resident's diagnoses included dementia, diabetes, anxiety, and depression. The resident's service plan included assistance with bathing, dressing, toileting, medication, administration, housekeeping, and laundry. The resident's assessment indicated she was at risk for falls and had self-care deficits.

The resident's progress notes indicated the resident and the resident's family member reported the resident fell out of bed during the night shift on a Saturday night. The family member and resident reported the incident to the nurse on Monday. The nurse updated the resident's provider who ordered an x-ray. The nurse noted bruising on the resident's shin and the resident complained of pain in her toe. The resident was offered an ice pack and pain medication. A follow-up progress note indicated no fractures were found.

The resident's incident report indicated the resident reported she fell out of bed and injured her foot. The resident was unable to remember when the incident happened but according to the family member the incident happened Saturday night. The resident's foot was assessed, pain medication and ice were offered, and an x-ray was ordered. No injuries were observed post incident.

The resident's pendent push log indicated the resident never pushed her pendant light the night she reported she fell out of bed.

The resident's most recent care conference note indicated the resident resisted care including incontinence cares and housekeeping. The resident's mental and physical health declined requiring increased support and monitoring. A decision was made between the care team and family to move the resident to memory care.

During an interview, a family member said the resident reported she fell during the night and staff never answered her call light. She said the resident reported the incident happened on a Saturday night and she reported the incident to the nurse and primary care provider the following Tuesday. She said the resident reported the incident to the night shift staff who told her she was fine and to go back to bed. She said the resident sustained significant bruising and a broken toe from the fall. She said the facility failed to provide medical care.

During an interview, unlicensed personnel (ULP)-1 who worked the night during the reported incident said the resident never reported she fell out of bed or injured herself during her shift. She said ULP-2, who worked with her during the night shift never reported the resident had an accident or fall during their shift.

During an interview, the nurse said a family member reported to her the incident happened over the weekend. She said the resident was unable to confirm what day the incident happened. She said neither the family or resident told her the resident told the staff member she fell or was injured over the weekend. When she learned of the incident on Monday, she assessed the resident and noted some bruising on the leg. She updated the provider and implemented interventions for pain management. She said the resident already received scheduled medications for pain and the resident was able to move her foot and walk. An x-ray indicated no fracture, and the resident has since healed and returned to baseline.

During an interview, a member of management said the resident was often confused, paranoid and resistive to cares. The resident reported she fell to the family but never reported the incident to facility staff. The nurse addressed the resident's injuries and communicated with family. An incident report was completed, and medical care was provided to the resident. After consulting with the family, the resident planned to move to memory care soon.

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, but the resident declined a recorded interview.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility updated the provider, assessed the resident and implemented interventions to ensure the resident's health and pain was managed.

Action taken by the Minnesota Department of Health:
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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: #HL202576168C/#HL202573243M On July 31, 2025, 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 141 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL202576168C/HL202573243M, tag identification 0460.	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.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all current residents. A pendent light was provided but the front desk staff were able to deactivate the alert without ensuring staff answered the resident's call for assistance. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 460		

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0 460	Continued From page 2 a large portion or all of the residents). The findings include: R1's diagnoses included dementia, depression, anxiety, and diabetes. R1's service plan indicated she received assistance with bathing, grooming, medication management, and housekeeping. During an interview July 31, 2025, at 11:25 a.m., R1 said when she pressed her call light staff failed to respond or took an excessive amount of time. During an observation July 31, 2025, at 11:30 a.m., MDH investigator pressed R1's pendant light. MDH investigator waiting in R1's room for 44 minutes and staff never responded. During an interview July 31, 2025, at 12:15 p.m., unlicensed personnel (ULP)-C said she was assigned to care for R1. She said R1's pendent was never pushed and she never saw an alert on her device that shows resident calls. ULP-C and MDH investigator went to R1's room and pushed R1's pendent together. Within seconds of pressing R1's pendent, ULP-c's device indicated an alert for R1's room number. R1's Pendent Push Log indicated R1's pendent alert was pushed at 11:30 a.m. and answered one minute and 52 seconds later. The log indicated the pendent alert was turned off by a "forced complete." During an interview July 31, 2025, at 12:30 p.m., assistant executive director (AED)-G and MDH investigator reviewed R1's pendent push log for the morning. AED-G said a "forced complete" indicated the person working at the reception	0 460		

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0 460	Continued From page 3 desk turned off the alert after a staff member reported via radio, they responded to the resident's call for help. She said staff can turn the call light alert of two different ways. First, they can use their assigned staff pendent and hold it up to the resident's pendent, push both buttons at the same time to deactivate the alert or staff can radio the front desk staff, and they can turn off the alert. During an interview July 31, 2025, at 12:53 p.m., ULP-C stated she never responded to R1's call because she was recently in her room. She said she assisted R1 about an hour before the pendent was pressed. The pendent push log dated May 2025, indicated R1 called for help 25 times. Seven of those 25 times, R1 waited over 45 minutes for assistance. They are logged as follows: - May 4, 2025, duration of call was 1 hour, 24 minutes, and 8 seconds. - May 6, 2025, duration of call was 1 hour, 13 minutes, and 26 seconds - May 6, 2025, duration of call was 1 hour, 33 minutes, and 12 seconds. - May 6, 2025, duration of call was 46 minutes, and 34 seconds. - May 6, 2025, duration of call was 49 minutes, and 56 seconds. - May 6, 2025, duration of call was 1 hour, 16 minutes, and 52 seconds. - May 7, 2025, duration of call was 46 minutes, and 17 seconds. During an interview July 31, 2025, at 2:30 p.m., AED-G along with registered nurse (RN)-H, and regional director (RD)-I present stated going forward all staff must deactivate the pendants from inside the resident's apartment with their	0 460		

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0 460	Continued From page 4 provided staff pendent. The front desk staff can no longer deactivate the alert. The licensee's 24-Hour Emergency Response police dated August 1, 2021, indicated all calls will be answered immediately and the system will be tested regularly. TIME PERIOD FOR CORRECTION: SEVEN (7) days	0 460		