Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202576583M
Compliance #: HL202575722C

Date Concluded: January 28, 2026

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:
Maerin Renee, 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) neglected the resident when she failed to follow the resident's care plan for transfers and the resident fell while toileting. The resident sustained bruising to her face and knee, and a broken toe.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The AP was following the resident's care plan and helped transfer the resident to and from the toilet. As the AP helped the resident transfer using a gait belt, the resident lost her balance and fell, landing on top of the AP. After the resident fell, the AP obtained help, staff helped the resident up and managed the incident per facility protocol.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included review of the resident record, death record, facility internal investigation, facility incident

reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident cares and interactions with staff.

The resident resided in an assisted living facility. The resident's diagnoses included chronic kidney disease; hemiparesis, right-sided; and generalized muscle weakness. The resident's services included assistance with activities of daily living, housekeeping, laundry, meals, and medication management. The resident's assessment indicated she was at high risk for falls.

A facility incident report indicated the AP was transferring the resident and the resident's feet slipped on the floor. The resident fell and hit her head on the bathroom wall. Staff noted a hematoma on top of the resident's scalp at the time of the fall. Staff did not observe any further injuries. Staff notified the resident's hospice provider and family, who came to visit resident. Staff called 911, but it was decided since the resident was on hospice she would not be sent in and she stayed at the facility. The resident's progress notes indicated after the fall she complained of pain to her right shoulder, her knees and legs, and the top of her head.

The resident's service/care plan in place at the time of the fall, and her most recent nursing assessment, indicated she was an assist of one for toileting and transfers. After the resident fell, nursing updated all resident documents to indicate the resident was an assist of two.

The medical examiner report indicated the resident's immediate cause of death was a "lung nodule concerning for malignancy." The medical examiner documented the resident's manner of death as natural.

When interviewed, a nurse said the resident was on hospice and her need for staff assistance varied day by day. When the AP helped the resident toilet, the AP said the resident stood up and then got scared. The resident said, "I can't, I can't" and then fell, landing on top of the AP. The resident had a previous fall, after which she went to a transitional care unit (TCU) for recuperation before returning to the facility. So, the resident had become anxious about transfers. Staff called 911, but the resident did not go to the hospital because she was receiving hospice services. The AP said she had transferred the resident twice that day and had no issues. After the fall, the nurse upgraded the resident to an assist of two staff members for transfers and toileting. The resident sustained bruising to her face. The nurse did not recall that the resident had a broken toe. The resident passed away soon after the fall.

When interviewed, the AP said she helped the resident to the toilet. The AP used a gait belt to help the resident back up and transfer to her wheelchair. However, the resident lost her balance and fell, landing on top of the AP. The AP called for help and another staff member helped both the resident and AP off the floor. Staff notified a nurse and called 911 and managed the fall per protocol.

When interviewed, family members said the resident did not like the AP and felt the AP rushed her during cares. The resident lived at the facility for several years and after an adjustment period, a family said the resident's care, overall, was good.

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: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an investigation into the fall and managed the fall per protocol.

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
	20257	A. BUILDING: _____ B. WING _____	C 12/16/2025

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 On December 16, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL202575722C/#HL202576583M. 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 ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	