

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report : HL203163533M
Compliance : HL203162941C

Date Concluded: September 14, 2026

Name, Address, and County of Licensee

Investigated:

Ecumen Centennial House of Apple Valley
14631 Pennock Avenue
Apple Valley, MN 55124
Dakota County

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

Evaluator's Name: Deb Schillinger RN BSN
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 neglected the resident when had a change in condition with neurological changes.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. An unlicensed caregiver noticed changes in the resident and notified the nurse appropriately. The nurse assessed the resident and arranged transport to the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record, death record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report and related facility policy and procedures. Also, the investigator observed resident and facility staff interactions during an onsite visit.

The resident resided in an assisted living memory care unit. The resident's diagnoses included vascular dementia, high blood pressure and high cholesterol. The resident's service plan included assistance with reminders, redirection and transferring to her wheelchair and escorting to activities. The resident's assessment indicated the resident had mild cognitive impairment, and required the assistance of one caregiver to transfer, dress and shower. The resident's choice was not to receive resuscitation (DNR).

The progress notes indicated an unlicensed caregiver #1 helped the resident get up in the morning and observed she was not herself. The unlicensed caregiver assisted her to breakfast however her concerns remained, so she contacted the nurse to assess the resident. Upon assessment, the nurse assessed her neurological condition, found she had symptoms of a possible stroke, and contacted EMS. The resident was transferred to the hospital.

The hospital records indicated the hospital diagnosed the resident with a stroke based on symptoms. A computer tomography showed the resident did not have an active bleed, however no further imaging was completed due to advanced age.

The resident returned to the facility and later enrolled in hospice.

During an interview, unlicensed caregiver #1 stated she noted subtle changes in the residents condition, she continued to monitor the resident and notified the nurse when symptoms were worsening.

During an interview, the nurse stated she came in at 1030 a.m. on the day of the incident and unlicensed caregiver #1 notified her of her concerns regarding the resident not being her usual self today. After an assessment, the nurse called EMS, who transferred the resident for advanced care.

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, the resident is deceased.

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: The facility staff transferred the resident when a change in condition was identified.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20316	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/14/2026
NAME OF PROVIDER OR SUPPLIER THE CENTENNIAL HOUSE APPLE VAL		STREET ADDRESS, CITY, STATE, ZIP CODE 14625 PENNOCK AVENUE APPLE VALLEY, MN 55124			
(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 July 14, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL203162941C/#HL203163533M. No correction orders are issued.	0 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE