Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL211831260M
Compliance #: HL211835395C

Date Concluded: April 15, 2026

Name, Address, and County of Licensee Investigated:
Flagstone
8350 Commonwealth Dr,
Eden Prairie, MN 55344
Hennepin County

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

Evaluator's Name: Brandon Martfeld, RN, BSN, Special Investigator

Finding: Substantiated, facility responsibility

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 the resident was found in bed incontinent with urine and stool resulting in hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident was to receive "I'm okay" checks daily. The checks were missed for two consecutive days. The resident was found by family in bed, incontinent with urine, and confused. The resident was transported to the hospital, diagnosed with influenza and sepsis (a life-threatening medical emergency caused by the body's extreme, overwhelming response to an infection, which triggers widespread inflammation and damages its own tissues and organs), and passed away approximately three weeks later while receiving hospice services.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, death record, hospital records, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included giant cell arteritis (GCA) with polymyalgia rheumatica (PMR) (GCA is a severe vasculitis affecting large vessels, causing headaches and vision loss, while PMR causes proximal joint pain/stiffness) and dementia. The resident's service plan included assistance with weekly medication management. The resident's assessment indicated the resident was independent with activities of daily living, walked independently with a walker and had intact cognition.

The resident's medical record indicated the resident's family attempted to call the resident and the resident did not answer. When the resident's family arrived, the resident was severely dehydrated and ill. The medical record indicated the daily "I'm okay" check for the resident was missed or was not completed for two consecutive days. The resident's family called emergency medical services, and the resident was transported to the hospital.

Hospital record indicated emergency medical services found the resident confused in bed and soaked with urine. When the resident arrived at the hospital, the resident had a fever, altered mental status, weakness, and difficulty speaking. The resident was hospitalized for 16 days. The resident was positive with influenza A and sepsis. The hospital record indicated the resident was in a very "tenuous condition" (a state that is extremely weak, fragile, uncertain, or shaky). The hospital record indicated the resident was treated with medication and antibiotics, but the resident remained bed bound with poor appetite and failed to thrive. The resident was started on comfort care and transferred to a higher level of care.

The resident's death certificate indicated the resident passed away six days after being discharged from the hospital. The resident's cause of death was complication from influenza A including sepsis.

The facility's documents and website indicated daily "I'm okay" checks would be completed for all residents.

The facility's investigation indicated the daily "I'm okay" checks were missed for the resident for two consecutive days. The facility had daily check sheets of all the residents and hung them up in the kitchen area. Culinary staff were to highlight the resident's name on the sheets to indicate the "I'm okay" checks were completed for the residents when they enter the dining room for breakfast and lunch. On the first day, the resident's name was highlighted green before breakfast started, which indicated the resident's "I'm okay" check was already completed by someone. Because the resident's name was highlighted, the resident was not included in the daily checks for residents that did not dine for breakfast or lunch that day. On the second day, the daily check sheet was not provided from the culinary team to the

receptionist. Because the receptionist never received the daily check sheet, the resident's "I'm okay" check was never completed.

During an interview, an unlicensed staff member stated the evening the resident's family called for help, she entered the resident's apartment and there was a "stinky foul smell." The resident was observed laying in a wet bed and the room smelled like urine. The resident was disorientated with a mouth dry. The unlicensed staff member stated the resident was trying to talk, but the resident could not be understood.

During an interview, facility leadership stated a facility investigation was completed and revealed the resident did not receive daily "I'm okay" checks for two consecutive days. The resident was transferred to the hospital and did not return to the facility. Facility leadership stated the daily "I'm okay" checks were to ensure the residents were safe.

During an interview, a family member stated after trying to call the resident multiple times without an answer, she drove to the facility. When they arrived, there was a package outside the resident's door that had been delivered the previous day. Upon entering the resident's apartment, there was a "terrible" smell, and the resident was moaning loudly. The resident was lying in a soiled bed, not able to talk, and her lips looked "terrible." The family member stated they called emergency medical services and facility staff. The resident was transported to the hospital and enrolled into hospice services. The resident moved to a higher level of care and passed away approximately a week later.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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 was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility educated staff on the process of completing the “I’m okay” checks.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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
Hennepin County Attorney
Eden Prairie City Attorney
Eden Prairie Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21183	A. BUILDING: _____ B. WING _____	C 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLAGSTONE	615 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

(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: #HL211831260M / #HL211835395C On March 24, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 57 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL211831260M / #HL211835395C, tag identification 2360.	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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident (R1) reviewed was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		