Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL256769702M
Compliance #: HL256764241C

Date Concluded: June 8, 2026

Name, Address, and County of Licensee Investigated:
Norris Square Long Term Care
6995 80th Street South
Cottage Grove, MN 55016
Washington County

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

Evaluator's Name: Maerin Renee, RN
Special Investigator

Finding: Inconclusive

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)/unlicensed personnel neglected the resident when they failed to respond to her call light. The resident fell, was hospitalized, and later died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Conflicting accounts of the incident were provided, and it was unable to be determined if neglect occurred. Upon finding the resident on the floor, staff immediately assessed the resident and sent the resident to the hospital for further evaluation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family, law enforcement, and external health care providers. 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 interactions with staff.

The resident resided in an assisted living facility. The resident's diagnoses included cardiovascular disease, legal blindness, and osteoarthritis. The resident's services included assistance with activities of daily living, housekeeping, meals, and medication management. The resident's assessment indicated she needed full assistance with all activities of daily living.

The facility's internal investigation into the incident indicated the AP answered a call light for the resident, at which point the resident informed the AP that she would need the nurse to help with her straight catheterization (intermittently inserting a tube through the urethra into the bladder to drain urine). The AP left the resident's room but did not inform the nurse of the resident's request.

After leaving the resident's room, the AP immediately went to assist two other residents who had activated their pendant alarms. The resident reactivated her call light, and the AP was seen sitting in the common area. The walkie-talkie system showed the call light was announced 5 times over 17 minutes. The nurse asked about the call, and the AP told the nurse it was for her, to assist with the straight catheterization. The nurse entered the resident's room and found her on the floor crying with a visible injury. The resident reported being on the floor for 30 minutes. Staff called 911, and a police report was filed. The AP was placed on administrative leave pending an investigation.

The resident's medical record indicated a nurse entered room to answer pendant call and found resident on floor. The resident's back was against the bed, and she cried, saying her leg was broken. The resident's left leg extended outward but was bent to the left at the knee in an L-shape. The nurse called 911 as the AP stayed with the resident. The resident was taken to the hospital via ambulance.

The resident's hospital records indicated on the night she fell, the resident had the urge to urinate, activated her call pendant and received no response. There was a bedpan on the floor, so the resident attempted to climb out of bed to use the bedpan. As she reached for the bedpan the resident fell out of bed, landing on her left leg. She felt the immediate onset of pain but did not hit her head nor incur other injuries. An x-ray revealed the resident sustained a left femur fracture. The resident could not bear weight on her left leg and required a mechanical lift for transfers. The resident was discharged back to the facility in stable condition.

A police report indicated the resident had fallen and yelled for help for 30-35 minutes before staff entered her room. Staff had been busy with other things and assumed the resident needed help with her straight catheterization. Emergency services personnel (EMS) transported the residents to the hospital. A nurse said when residents pressed their pendants, the nurse received an alert. The nurse said the resident's pendant alarm went off around 6:30 p.m., and the resident was due to be straight catheterized around 7:00 p.m. The nurse said the resident

would occasionally press her pendant if she needed to be straight catheterized earlier than scheduled. The nurse said she was responsible for straight catheterization; however, caregivers were responsible for checking in with residents if they pressed their call pendants. In this case, the nurse instructed the AP to check on the resident. After a period of time, the resident's call pendant alarmed again. At that point the nurse checked on the resident and found her on the floor yelling for help. The resident had fallen and broke her leg. The nurse was frustrated with the AP, as she had been busy with a phone call and unable to check on the resident herself. The nurse said she delegated that task to the AP. The AP said he was busy helping another resident when the resident's call light alarmed. He thought the nurse would respond, since the resident was due for her straight catheterization.

The resident's pendant report indicated her pendant alarmed once for about 17 minutes and then again for 11 seconds.

Per the coroner report, the resident's immediate cause of death listed complications of left femoral fracture due to fall. The manner of death was an accident.

When interviewed, a supervisor said the AP was assigned to work with the resident. The resident told the AP the next time she activated her pendant, it would be for the nurse to help with her straight catheterization. When the resident's pendant alarmed, the nurse was busy and told the AP to check on her. The AP said the call was for the nurse. When staff did not respond to the original pendant alarm, the resident attempted to reach for her bed pan under the bed and fell to the floor.

When interviewed, a nurse said the nurse would straight catheterize the resident after she got ready for bed. So, when the resident's pendant alarmed, the AP assumed it was for the nurse. The nurse told the AP he needed to address pendant calls regardless of who he thought they were for. The nurse checked on the resident and found her on the floor. The nurse had not experienced issues regarding the AP answering pendant alarms on previous shifts but was frustrated that the AP made an incorrect assumption in this case.

When interviewed the AP said he helped the resident get ready for bed. The resident told him the next time she activated her call pendant it would be for the nurse to straight catheterize her. When he left the resident's room, the AP immediately answered pendant calls from two other residents. When the AP finished with the other two residents, he sat down in the hallway and immediately heard a pendant alarm for the resident. The AP said he knew the call was for the nurse, so when the nurse came out of the office, the AP told the nurse the resident was calling for her. The AP said he did not hear the resident's previous pendant alarm, because he was helping the other two residents. The nurse went into the resident's room and found her on the floor. The AP stayed with the resident until EMS arrived and transported her to the hospital.

The resident's family declined to interview as they had no complaints.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: No, the family had no concerns and declined to interview.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility completed an internal investigation and provided re-training to staff.

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
	25676	A. BUILDING: _____ B. WING _____	C 04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS SQUARE	6995 80TH STREET SOUTH COTTAGE GROVE, MN 55016

(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 April 14, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL256764241C/#HL256769702M. 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.	