Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL273089222M
Compliance #: HL273083161C

Date Concluded: April 16, 2026

Name, Address, and County of Licensee Investigated:
Cherrywood Richmond
140 Barry Ave
Richmond, MN 56368
Stearns County

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

Evaluator's Name: Lena Gangestad, 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 facility neglected the resident after he was found on the floor, resulting in a hip fracture.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The resident experienced a fall, and the incident was an isolated incident. As a result of the fall, the resident sustained a hip fracture. Hospice was notified, and appropriate adjustments were made to the resident's pain management plan.

The investigator conducted interviews with administrative staff and family member. The investigation included review of the resident's records, incident reports, staff schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia. The resident's service plan included assistance with all activities of daily living. The service plan also included safety checks every two hours and as needed.

A concern arose after the resident was found on the floor. The on-call nurse was notified, and vital signs were monitored every four hours for 24 hours per nursing instruction. At the time of the fall, the resident denied hip pain and declined transfer to the emergency department for further evaluation. The resident's family member, primary care provider (PCP), and hospice were notified of the incident.

During an interview, the nurse reported the resident fell during the night. She stated the resident's vital signs were within normal limits. The nurse said the resident was offered the option to go to the hospital for evaluation but declined. She further stated the resident had existing medication orders for Tylenol scheduled twice daily, morphine every two hours as needed, and tramadol every four hours as needed for pain management. Due to the resident's continued reports of leg pain, an X-ray of the right hip was ordered. The imaging results confirmed a fracture of the right femur with arthritic changes in the right hip joint. The nurse said there was a delay in obtaining the X-ray due to the holiday. She also stated because the resident's pain was not adequately controlled with as needed medications, the primary care provider was notified and revised the pain management plan by changing medications from as-needed dosing to a scheduled regimen.

During an interview, the resident's family member stated the facility notified her of the fall and later informed her once the hip fracture was confirmed. She said the resident's pain medication had been changed from as needed to scheduled dosing. The family member also said the resident was receiving hospice services and had previously expressed he did not want to be transferred to the hospital. The family member said staff had done what they could to care for the resident and expressed no concerns regarding the care provided.

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, unable to interview due to dementia.

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

Action taken by facility: The facility notified hospice, the family member, and the primary care provider. They also contacted the primary care provider to adjust the pain management regimen as the resident's pain increased.

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
	27308	A. BUILDING: _____ B. WING _____	C 02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD RICHMOND	140 BARRY AVENUE NW RICHMOND, MN 56368

(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 February 17, 2026, the Minnesota Department of Health initiated an investigation of complaints #HL273089222M/HL273083161C. No correction orders are issued.	0 000		