Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL279814002M
Compliance #: HL279817847C

Date Concluded: August 18, 2025

Name, Address, and County of Licensee Investigated:
Fridley Assisted Living
6352 Central Ave NE
Fridley, MN 55432
Anoka County

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

Evaluator's Name: Brandon Martfeld, RN, BSN, 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 facility neglected the resident when the resident obtained a left hip fracture of an unknown cause.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Facility staff provided care to the resident according to her needs and reported left hip swelling and pain with movement immediately to the nurse. The facility investigation concluded the resident did not have any witnessed or unwitnessed falls. It could not be determined how the resident fractured the resident's left hip.

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

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, aphasia (language disorder that affects a person's ability to communicate) and chronic pain. The resident's service plan included assistance with bathing, eating, dressing, grooming, medication administration, mobility, and required two staff with a mechanical lift for transfer. The resident's assessment indicated the resident had a poor appetite, was severely cognitively impaired and was non-verbal.

The facility internal investigation indicated one day the resident was experiencing signs and symptoms of pain to her left hip. The left hip was observed to have mild swelling with no bruising present. An x-ray was ordered from the resident's primary care provider and revealed the resident sustained a left hip fracture. The resident's family member requested the resident not be sent to the hospital and requested the resident be evaluated for hospice services. The resident was admitted to hospice. The facility internal investigation indicated staff were interviewed, the resident was nonverbal and was not able to be interviewed. The facility's communication notes indicated the resident did not sustain a witnessed or unwitnessed fall.

During an interview, unlicensed personnel stated the resident required assist from staff for activities of daily living. The unlicensed personnel denied the resident had a fall or was unaware of what may have caused the fractured left hip.

During an interview, a nurse stated they were alerted by staff members that the resident's left hip was swollen, and that resident was showing signs and symptoms of pain. The resident's primary care provider was notified, an x-ray was ordered, and the resident was started on hospice services. The nurse stated the resident's family decided to keep the resident comfortable and admit the resident to hospice care.

During an interview, a family member stated the resident had a family history of scoliosis, brittle bones, and osteoporosis. The resident bruised easily and at the time of the incident there was no bruising to suspect abuse.

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

Action taken by facility:
The facility notified the resident's primary care provider, obtained an order for an x-ray and orders for hospice evaluation.

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
	27981	A. BUILDING: _____ B. WING _____	C 08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIDLEY ASSISTED LIVING LLC	6352 CENTRAL AVENUE FRIDLEY, MN 55432

(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 August 12, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL279814002M/#HL279817847C. No correction orders are issued.	0 000		