

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL282276122M
Compliance #: HL282274540C

Date Concluded: February 23, 2026

Name, Address, and County of Licensee

Investigated:

Oak Park Senior Living
13936 Lower 59th St. North
Oak Park Heights, MN 55082
Washington County

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

Evaluator's Name: Christine Bluhm, 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 Allegations: The alleged perpetrator (AP) neglected the resident when she found the resident deceased on the floor and did not report a potential fall and possible new injuries. Additionally, the AP called 911 and cardiopulmonary resuscitation was initiated by first responders, however the resident's advanced directives included do not resuscitate (DNR).

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was inconclusive. The AP found the resident deceased but did not clearly communicate if she witnessed the resident fall or if she found the resident on the floor. It was true CPR was initiated by first responders, however when paramedics arrived the advanced directive was clarified and CPR discontinued.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, death record, facility internal investigation, facility fall incident reports, personnel files, staff schedules, the 911 audio call, law enforcement reports, and related facility policy and

procedures. Also, the investigator observed facility activities and interviewed staff and residents in the memory care units.

The resident resided in an assisted living memory care unit with a diagnosis of Alzheimer's disease. The resident's assessment indicated the resident was at risk for falls. Previously, she had been independent with mobility and used a walker but, after a fall with an injury and a decline in mobility, had been enrolled in hospice. The resident's code status was DNR.

The resident's signed Physician's Order for Life Sustaining Treatment (POLST) indicated DNR if the resident was found with no pulse and no respirations.

A concern arose on the night the resident passed away when the AP, an unlicensed caregiver working the night shift, reported the resident had died to the on-call nurse and the resident's family. However, other details were not clearly communicated such as the resident was found on the floor, passed away with potentially new injuries, 911 had been called, and CPR initiated but then discontinued when the POLST was reviewed.

A 911 audio call indicated the AP called 911 and told dispatch that the resident was on the floor, and she did not think the resident was breathing. The dispatcher asked the AP "are we going to do CPR?" and the AP responded, "I think so, yes." The dispatcher instructed the AP to roll the resident on her back and then walked the AP through the steps of CPR over the phone.

The facility's internal investigation included a written statement given by another unlicensed caregiver who was working the same night shift with the AP but on a different unit. This document indicated the AP came to his unit to ask for help because the AP had been reaching out to the "float" unlicensed caregiver [who rotated between the memory care and the regular assisted living unit] but was getting no response. The AP told the caregiver she had called 911. The caregiver went with the AP back to the memory care unit where the resident was lying on the floor.

Police reports indicated first responders utilized an Automated External Defibrillator (AED) and started CPR because the AP stated there was not an active DNR order in place. When the ambulance crew arrived, POLST was found and reviewed so CPR was discontinued.

During an interview, the float unlicensed caregiver stated the AP asked for her help. When the float went down to the memory care unit, the AP had already called 911. The float stated it was clear the resident was on hospice.

During an interview, the on-call nurse stated she received multiple phone calls from the facility regarding the resident's death. The first call was from the float unlicensed caregiver, who told her the resident had passed away and, without any further details, the nurse did not realize the other details. Later, the AP called her saying she could not reach the family. The AP called again asking where to find hospice contact information. The on-call nurse stated they did not discuss

any further details such as the resident was on the floor, injuries, nor CPR. Not knowing any of this, the nurse sent a group text to the memory care phones indicating the resident was presentable in case family came to view her before the resident was taken from the facility. The nurse stated she did not hear anything more until morning when she saw that a family member had texted hours earlier that she wanted to be called right away.

During interview, a nurse manager stated all residents have a book in their apartment that contains the medication record along with POLST information. The resident's book in place however the AP apparently did not utilize it initially. The nurse stated unlicensed caregiver receive training on who to call when a fall or death occurs. While the AP did not follow these steps, she did seek help from other caregivers.

During interviews, family member(s) stated they received news of the resident's death, went to the facility and were met by a police officer at the resident's door. The resident was still lying on the floor, partially clothed, and had to be covered up by family. The AP could not explain what happened when questioned and left the unit and could not be reached again. The family waited for four hours to hear from the facility to return their calls. The family stated they had questions about the apparent injuries the resident had and how she came to be on the floor. The on-call hospice nurse did make a visit in the aftermath of the resident's death.

The death records indicated the manner of death was natural and the cause of death was related to late onset Alzheimer's Disease.

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.

(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:

- (i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
- (ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
- (iii) the error is not part of a pattern of errors by the individual;
- (iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
- (v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
- (vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: No, the resident was deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: No, the AP declined an interview with the investigator.

Action taken by facility: The facility reviewed the procedures for resident falls, deaths, and hospice with all caregivers, which was completed on each unit and with one-to-ones. The facility added communication to identify which residents were on hospice. The AP was no longer employed at the facility.

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: 28227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER OAK PARK SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 13936 LOWER 59TH STREET NORTH OAK PARK HEIGHTS, MN 55082
---	--

(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS: #HL282275622M / HL282273220C and #HL282276122M / HL282274540C</p> <p>On November 20, 2025, the Minnesota Department of Health initiated a complaint investigation at the above provider.</p> <p>No correction orders were issued.</p>	0 000	<p>fMinnesota 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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
-------	---	-------	--	--

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------