

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL282279183M  
**Compliance #:** HL282273142C

**Date Concluded:** March 10, 2026

## **Name, Address, and County of Licensee**

### **Investigated:**

Oak Park Senior Living  
13936 Lower 59<sup>th</sup> Street North  
Stillwater, MN 55028  
Washington County

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

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

**Finding:** Substantiated, individual 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 alleged perpetrator (AP), a facility staff member, neglected the resident when the resident sustained a fall and was found on the floor over 12 hours later.

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to complete the resident's scheduled evening cares. The resident fell in the evening before the scheduled cares and was found by staff the following morning. The resident was transported to the hospital for an evaluation. During the investigation it was identified that the AP had a pattern of not completing services for residents and documenting that the services were completed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, personnel files, staff

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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 lumbago with sciatica (lower back pain that is accompanied by pain, numbness, tingling, or weakness that radiates down one or both legs along the path of the sciatic nerve), osteoporosis, and rheumatoid arthritis. The resident's service plan included assistance with evening care, which included assistance with pajamas, using the bathroom, and assisting in and out the bed. The resident's assessment indicated the resident had memory impairment. The resident's assessment indicated the resident was independent with transfers, mobility, and used a walker for short distances.

The facility investigation indicated a staff member went to complete morning cares for the resident and found the resident on the floor between her living room and dining room. The resident stated she fell at approximately 5:00 p.m. the evening before. The facility investigation indicated the resident was on the floor for approximately 15 hours. The resident's bed was found still made and all the apartment lights were on. The resident's call pendant was attached to the resident's walker handle. The resident could not reach the call pendant and call for assistance. The resident was assessed by a facility nurse and sent to the hospital for an evaluation.

The hospital record indicated the resident was hospitalized for seven days following a fall. The resident did not suffer any fractures but did sustain a bruised right hip. The resident's hospital stay was complicated by an influenza infection. The resident was discharged from the hospital to a higher level of care.

Facility leadership completed an interview with the AP. The AP stated she did not see the resident and did not enter the resident's apartment at all during her shift. The AP stated she assumed the resident was out with family members because it was a holiday. The AP stated she did not complete the evening services for the resident, even though she documented the services as completed.

Review of the service checkoff list indicated evening care was to be completed at 8:30 p.m. The service checkoff list indicated the resident's evening cares included assistance from one staff for dressing into pajamas, grooming, toileting, changing incontinence product, ensuring proper peri-care and assistance into bed. In addition, staff were to ensure the resident was wearing her call pendant. The AP falsely documented she completed the evening cares for the resident.

The AP's personnel file indicated the AP had two disciplinary actions against her over the course of 15 months prior to the incident of the resident falling. The AP worked an evening shift and then worked a day shift the following day. A resident was found with a "strong odor" in a soiled brief, wearing a "dirty" night shirt and "dirty" pants. The resident's groin area was reddened. Facility leadership determined services were not completed by the AP even though the AP

documented services were completed for the resident. Seven months later, facility leadership determined the AP did not complete services for another resident, and again the AP documented services as being completed.

During an interview, multiple unlicensed staff members stated the resident services can be viewed on phones they are required to carry. Any new services for a resident, would be indicated on the phone a new service had been added for a resident. If staff need additional assistance, a text can be sent through the phones to ask for assistance from other staff members. Multiple unlicensed staff members stated the workload was manageable and denied any concerns with staffing issues.

During an interview, a nurse stated the resident had new services added because of a change in condition two days prior to the fall. The resident needed assistance with evening cares for getting ready for bed. The nurse stated the AP was aware of the resident's new services because the AP signed off as the service being completed, even though the service was not completed. The nurse stated the AP had a pattern of documenting services being completed even though services were not completed.

During an interview, the resident stated the night of incident staff did not come to assist her with her evening care. The resident stated she was on the floor all night until an unlicensed staff member found her in the morning.

The AP declined to be interviewed.

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.

(d) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:

(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with that

authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:

- (i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or
- (ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; or
- (2) the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult;
- (3) the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:
  - (i) a person including a facility staff person when a consensual sexual personal relationship existed prior to the caregiving relationship; or
  - (ii) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship; or
- (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:** Yes.

**Family/Responsible Party interviewed:** Yes.

**Alleged Perpetrator interviewed:** No. The AP declined an interview.

**Action taken by facility:**

The facility completed an internal investigation, suspended the AP, and completed training with unlicensed staff on completion of services and signing off once the service has been completed. The AP is no longer employed by the facility.

**Action taken by the Minnesota Department of Health:**

The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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>

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care  
The Office of Ombudsman for Mental Health and Developmental Disabilities  
Washington County Attorney  
Stillwater City Attorney  
Stillwater Police Department

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>28227</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/03/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>OAK PARK SENIOR LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>13936 LOWER 59TH STREET NORTH OAK PARK HEIGHTS, MN 55082</b>
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(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
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER CORRECTION ORDER</b></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:</p> <p>#HL282279183M / #HL282273142C #HL282279402M / #HL282273543C</p> <p>On February 3, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 94 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction orders are issued for #HL282279183M / #HL282273142C, tag identification 02360.</p> <p>No correction orders are issued for #HL282279402M / #HL282273543C.</p>	0 000	<p>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.</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>	
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>Residents have the right to be free from physical,</p>	02360		

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

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02360	<p>Continued From page 1</p> <p>sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of two residents reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p>	02360	<p><b>RECEIVED A REQUEST FOR RECONSIDERATION</b></p>	
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