Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL282279402M
Compliance #: HL282273543C

Date Concluded: March 10, 2026

Name, Address, and County of Licensee Investigated:
Oak Park Senior Living
13936 Lower 59th St N
Stillwater, MN 55028
Washington 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 alleged perpetrator (AP), a facility staff member, neglected the resident when the AP left the resident on the toilet for approximately one and one-half hour. The resident sustained a fall while self-transferring off the toilet.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The AP assisted the resident into the bathroom to use the toilet. The AP received a call from another resident and went to assist. When the AP returned to the resident's apartment, the resident was found on the floor in the kitchen area of the apartment. Due to conflicting documentation and interviews, it could not be determined that the resident's fall would have been prevented had the AP stayed with the resident while she used the toilet.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records,

death record, facility internal investigation, facility incident reports, personnel files, 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 traumatic brain injury and dementia. The resident's service plan included assistance with showering, and morning cares, which included assistance to the toilet, washing up, applying clean clothes, and brushing teeth. The resident's service plan indicated staff were to check the resident's toilet to ensure she did not overflow the toilet with toilet paper or other items. The resident's assessment indicated the resident received hospice services, had moderate cognitive impairment and was independent with transfers and walking. The resident's assessment indicated the resident required supervision from staff with toileting.

An incident report indicated the AP assisted the resident to the toilet and left to help another resident. When the AP returned to the resident's apartment, the resident was found lying on the floor in the kitchen area, with a dining room chair tipped over next to her. Hospice was notified, an x-ray was ordered, and it was determined the resident sustained a fractured hip. It was determined the resident would remain at the facility, and hospice would continue to provide comfort cares and pain management.

The facility investigation revealed the AP assisted the resident on the toilet and left the resident's apartment. Initially the AP told the facility leadership that she had left the resident for 25 minutes and when she returned the resident was on the floor. Leadership reviewed the facility camera footage, and it was revealed the AP did not return to the resident's apartment for one hour and 26 minutes. When the AP returned to the resident's apartment, the resident was found on the floor, and the facility nurse was notified of the fall. The resident sustained a fractured femur.

During an interview, an unlicensed staff member stated she arrived in the memory care unit to start an activity and noticed the resident was not at the activity that she normally attended. The unlicensed staff member stated she went to the resident's apartment to check on her. Upon entering the resident's apartment, the resident was in the bathroom, seated on the toilet. The unlicensed staff member asked the AP if the AP was going to shower the resident or if she should be brought down to an activity. The AP reported she was going to give the resident a shower.

During an interview, the AP stated she assisted the resident into the bathroom to get ready for the day. The resident was using the toilet when another resident called for assistance. She left the resident on the toilet and went to assist the other resident. The AP stated that when she returned to the resident's apartment, the resident was found on the floor in the kitchen with a dining room chair tipped over next to her. The AP stated the resident's services did not indicate whether or not she had to stay with the resident while she was on the toilet.

During an interview, a facility nurse stated the resident was independent with transferring and walking and required supervision for toileting. The resident's service plan directed the unlicensed staff members to assist the resident to the toilet. The resident needed supervision from staff when using the toilet because the resident had a history of using a whole roll of toilet paper and clogging the toilet. The facility nurse stated staff were expected to check on the resident 10 to 15 minutes after assisting the resident to the toilet; however, the service plan did not direct staff to complete the check.

During an interview, a family member stated the resident's mobility varied day to day. At times the resident would use a wheelchair but then there were days the resident would walk with or without a walker. Staff were to assist the resident to the toilet and then assist with any cares after using the toilet. When the resident fell, hospice was notified, and it was determined the resident was to remain at the facility because the resident was too frail to go through surgery. An x-ray was ordered the day after she fell, and it revealed the resident sustained a fractured hip. Hospice assisted with getting the resident a hospital bed and managed the pain. The family member stated the resident passed away five days after falling.

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. Resident had passed away.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility notified hospice, and family of the fall. The facility completed an internal investigation and provided education to the facility staff regarding documentation of completed services and providing details in an incident report. The AP is 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28227	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK SENIOR LIVING	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	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. INITIAL COMMENTS: #HL282279183M / #HL282273142C #HL282279402M / #HL282273543C 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. The following correction orders are issued for #HL282279183M / #HL282273142C, tag identification 2360. No correction orders are issued for #HL282279402M / #HL282273543C.	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of two residents reviewed (R1) was free from maltreatment. Findings include: 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.	02360		