*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL286057284M
**Compliance #:** HL286056984C

**Date Concluded:** February 9, 2026

**Name, Address, and County of Licensee Investigated:**
Summit Hill Senior Living
1824 Old Hudson Rd
St. Paul, MN 55102
Ramsey County

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

**Evaluator's Name:** Brandon Martfeld, RN, BSN, 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 when they failed to provide cares, services, and supervision. As a result, the resident fell and was hospitalized.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was not substantiated. The facility assessed and had services in place to assist with the resident's cares and supervision. Although the resident had an unwitnessed fall, staff were following the resident's plan of care. The resident did not sustain serious injuries, was transported to the hospital per the family member's request and was transferred to a higher level of care.

The investigator conducted interviews with facility staff members, nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital 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, psychosis, and paranoia/delusions. The resident's service plan included assistance with safety checks three times a day, toileting, dressing and bathing. The resident's assessment indicated the resident was independent with transfers, walking, and bed mobility. The resident's assessment indicated the resident needed assist of one staff for grooming, bathing and required standby assist with dressing.

The resident's medical record indicated an unlicensed staff member went to the resident's room to get her for breakfast. The resident was found on the floor and the resident reported that she fell from the bed. The medical record indicated the resident sustained an abrasion to her right knee. The resident was transferred to the hospital for an evaluation.

The hospital record indicated the resident had an unwitnessed fall, complained of pain all over, had bilateral knee abrasions and that it was unclear of the total duration of time the resident was on the ground. The resident did not sustain any fractures, and the resident was provided with intravenous fluids. During the hospitalization the resident exhibited stroke-like symptoms, was hospitalized for five days and transferred to a higher level of care.

During an interview, unlicensed staff member stated the resident was able to walk independently but needed assist of one staff for dressing and bathing. The day of the fall, the resident was checked on approximately two hours prior to the fall. The resident was in bed and appeared to be sleeping before breakfast, and the staff gave the resident her medications. The unlicensed staff member stated she went to get the resident for breakfast, and the resident was found on the floor next to her bed. The resident stated she fell out of bed. The unlicensed staff member stated she called for assistances from a co-worker and notified the nurse in the facility.

During an interview, a nurse stated the resident stated she fell from the bed and onto the floor. The resident was transferred to the hospital at the request of the family member. A couple days prior to the unwitnessed fall, services were increased to include safety checks per the request of resident's family member. The staff are educated to document the number of times a service was completed in the service delivery record.

The service delivery record indicated services were completed for the resident as scheduled.

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. Resident resided at a different facility.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: Not Applicable.

**Action taken by facility:**
When the resident was found on the floor, the nurse was alerted and assessed the resident. The resident was transferred to the hospital for 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 |
|---|---|---|---|
| | 28605 | A. BUILDING: _____ B. WING _____ | C 01/13/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUMMIT HILL SENIOR LIVING | 1824 OLD HUDSON ROAD SAINT PAUL, MN 55119 |

| (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<br><br>On January 13, 2026, the Minnesota Department of Health initiated an investigation of complaints #HL286057284M / HL286056984C and HL286058644M / HL286051684C. No correction orders are issued. | 0 000 | | |