Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL287903622M
Compliance #: HL287906868C

Date Concluded: August 6, 2025

Name, Address, and County of Licensee Investigated:
Towerlight on Wooddale Avenue
3601 Wooddale Ave. South 313
Saint Louis Park, MN 55416
Hennepin County

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

Evaluator's Name: Brooke Anderson, RN
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 the resident was found soiled, full of urine and feces, confused with a fever, pain, and infected wound on his left hip.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Facility staff followed the plan of care for the resident. Although a wound became infected, the wound was managed by hospice staff. The facility provided care in collaboration with outside hospice agency staff and the resident's provider.

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 incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included stroke and Parkinson's disease. The resident's service plan included assistance with dressing, grooming, toileting, and medication management. The resident's assessment indicated the resident was orientated to person and place and was enrolled in hospice care.

Medical records indicated hospice staff found the resident incontinent during a visit. Records indicated the resident was toileted as scheduled by facility staff but had an incontinent episode in between the scheduled times. Eight days later, the resident's wound was found to be infected. Medical records indicated the resident was toileted as scheduled and facility management made attempts to have the hospice nurse complete dressing changes on the wound more frequently.

The internal investigation indicated the resident needed hands-on assistance with all cares. The resident developed a right hip wound. Hospice managed the dressing changes for the wound weekly. When the wound worsened, the facility requested an increase in hospice visits. Approximately one week later, the wound became infected. The facility updated the provider, and the provider ordered an antibiotic for treatment.

During an interview, a facility staff member stated staff were not to change the dressing on the wound but to report concerns to the hospice nurse or facility nurse. The staff member provided care the day the resident's wound was found to be infected. The staff members stated she completed morning cares including toileting and the wound bandage was not soiled and was intact. The day the wound was found infected, the hospice nurse changed the dressing and reported the wound was infected to facility staff.

During an interview, the hospice nurse stated hospice managed the wound and facility staff were allowed to remove the wound dressing only if the bandage was soiled. The hospice nurse stated the day she found the wound infected she noted an odor in the room and when checking the wound, the bandage was not soiled.

During an interview, facility management stated they did not manage the resident's wound. The wound was managed by hospice staff and in the weeks prior to it becoming infected, facility management had requested for hospice to change the dressing three times per week; however, documentation indicated the hospice nurse was only assessing the wound weekly. When facility staff reported the wound had worsened, management reached out to the medical provider and obtained new wound care orders. The orders were implemented and a new hospice nurse was assigned to the resident and the infection cleared.

During an interview, a family member stated that although the care could have been better at the facility, the wound was not managed by the facility. Hospice managed the wound and after the wound declined, the hospice nurse increased her visits.

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 is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
The facility reported the wound changes to the hospice nurse and medical provider.

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
	28790	A. BUILDING: _____ B. WING _____	C 07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWERLIGHT ON WOODDALE AVENUE	3601 WOODDALE AVENUE SOUTH SAINT LOUIS PARK, MN 55416

(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 July 28, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL287906868C/#HL287903622M . No correction orders are issued.	0 000		