Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL288875402M
Compliance #: HL288872720C

Date Concluded: October 21, 2025

Name, Address, and County of Licensee Investigated:
The Landmark of Fridley
6490 Central Ave NE
Fridley, MN 55432
Anoka County

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

Evaluator's Name: Lori Pokela R.N.
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 facility failed to administer physician ordered Parkinson's medication or treat a urinary tract infection (UTI), resulting in a fall and hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell and sustained fractures, the resident's service plan, and medication administration records were followed at the time the incident occurred. Additionally, when the resident showed signs of a UTI, the medical provider was updated, and the resident was treated with antibiotics.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of the resident record(s), hospital records, pharmacy records, facility incident reports, personnel files, staff schedules and related facility

policy and procedures. Also, the investigator observed the facility's physical plant, observed medication administrations, cares and staff interaction with the residents.

The resident resided in an assisted living facility. The resident's diagnoses included Parkinson's disease, osteoarthritis and a history of UTIs. The resident's service plan included dressing, toileting, transfers, safety checks and medication management. The resident's assessment indicated the resident was alert and orient with forgetfulness, confusion and impaired decision-making skills. Additionally, the assessment indicated the resident had a history of multiple falls, including falls associated with UTIs, balance problems and used a walker and wheelchair for mobility.

An incident report indicated the resident had pressed her emergency pendent and staff found the resident laying down on her side in the kitchen bleeding from her nose. The resident reported she was walking with her 4-wheeled walker when she tripped and fell forward. 911 was notified and the resident was sent to the hospital for evaluation.

Hospital records indicated the resident sustained multiple fractures, including fractures to her face and right wrist. Hospital records indicated the resident was diagnosed with orthostatic hypotension [a condition where blood pressure drops significantly when a person stands up from a sitting or lying position]and was treated with an antibiotic for a UTI then discharged to a new facility.

Review of the resident's medical records indicated facility staff administered the resident's medications per the medical providers orders. The resident's pharmacy completed a medication review for the date of the incident. The medication review indicated the resident's Parkinson's medication administered prior to the fall would have been active in the resident's body at the time of the incident and was administered within the time sensitive parameters.

During an interview, a facility administrative nurse stated the resident had frequent falls and new interventions were put in place to prevent reoccurrence. The resident was on Parkinson's medication that was needed to be given at precise times so the facility placed the parameters on the resident's medication administration to remind the facility staff that those medications were a priority for the resident.

During an interview, the resident stated she felt safe at the facility but had past concerns regarding her medication not being administered when she needed them but had since been resolved. The resident recalled having fallen multiple times during her stay at the facility with one fall resulting a fall landing on her face. The resident stated that after that fall occurred, she used her call light for assistance and has not fallen since.

During an interview, the resident's family member stated he had concerns with the resident's urinary tract infections, falls and medication administration. The resident was moved to a different facility after the hospitalization.

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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility completed incident reports.
The facility reported all documented incidents to the resident’s family member(s).
The facility reported, assessed and treated urinary tract infections.

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
	28887	A. BUILDING: _____ B. WING _____	C 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDMARK OF FRIDLEY	6490 CENTRAL AVENUE NE FRIDLEY, MN 55432

(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 September 11, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL288872720C/#HL288875402M. No correction orders are issued.	0 000		