Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL294466962M
Compliance #: HL294466443C

Date Concluded: December 17, 2025

Name, Address, and County of Licensee Investigated:

Heritage Pointe Senior Living
207 North 4th Street
Marshall, MN 56258
Lyon County

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

Evaluator's Name: Lena Gangestad, 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 alleged perpetrator (AP) neglected the resident by failing to escort her to the dining room as required in her care plan.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The AP, an unlicensed caregiver, made an isolated error when she did not finish escorting the resident to the dining room. The AP became distracted when unlicensed caregiver #2 asked her to help with another resident's cares. The resident fell and sustained a frontal sinus fracture, was evaluated at the hospital, but returned the same day with no new orders. The resident subsequently returned to her baseline condition.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigation included review of the resident's records, internal investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia. The resident's service plan included assistance with all activities of daily living, as well as escort services to and from meals and preferred activities. The assessment indicated she required one-person assistance with a gait belt and walker for ambulation.

One morning, the AP assisted the resident with her morning cares and followed her out of the apartment. However, the AP began assisting a different resident and did not escort the resident to the dining room and left the resident unattended in the hallway. The resident turned around, returned to her apartment leaving her walker in the hallway, and fell.

During an interview, the AP stated was walking with the resident when unlicensed caregiver #2 asked for assistance with another resident. She said she went to help leaving the resident to walk to the dining room alone. The AP acknowledged the care plan indicated the resident required assistance walking to the dining room and expressed remorse over the error.

During an interview, unlicensed caregiver #2 stated she asked the AP for help with another resident but did not intend for her to leave the resident unattended. She said that after assisting her resident, she passed by the resident's room and found her on the floor.

During an interview, a manager, who was also nurse, stated after reviewing the camera footage, she observed the AP leave the resident alone in the hallway and the resident returned to her apartment where she fell. She stated the AP had gone to assist another resident. The manager stated the AP had no prior disciplinary history.

During an interview, a family member stated the facility called to notify her of the fall. The family said the facility provides excellent care, and she had no concerns.

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.

(d) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
(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: No, the resident was diagnosed with dementia.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: Immediate education was provided to the AP on following resident care plans. The resident’s care plan was reviewed, and the transfer and mobility status were updated based on current needs. Additional education on resident care plans will be completed at the upcoming home health aid’s meeting. Post-fall monitoring continued.

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
	29446	A. BUILDING: _____ B. WING _____	C 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE POINTE SENIOR LIVING	207 NORTH 4TH STREET MARSHALL, MN 56258

(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 November 18, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL294466962M/ HL294466443C. No correction order is issued.	0 000		