DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304793309M
Compliance #: HL304792646C

Date Concluded: August 12, 2026

Name, Address, and County of Licensee Investigated:
Southern Oaks Place
10669 Ulysses St NE
Blaine, MN 55449
Anoka County

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

Evaluator's Name: Lori Pokela R.N.
Special Investigator

Finding: Substantiated, facility responsibility

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):
Neglect occurred after the resident returned from the hospital and staff did not monitor or provide care to the resident which resulted in a further health decline.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to have a process in place to ensure the oncoming shift received updates about the residents. Because of the failure, the resident returned from the hospital and did not receive service until the following day when the resident was found on the floor and sent back to the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted hospital staff. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

Also, the investigator observed medication and treatment administrations, cares provided, and staff interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease. The resident's service plan included assistance with bathing, toileting and medication management. The resident's assessment indicated the resident was independent with transfers and walked with a walked independently. The resident's assessment indicated the resident required assistance with medication management even though the resident did not have any scheduled medications at the time of the assessment. The resident's assessment indicated the resident was disoriented, had dizziness, had every two-hour safety checks and was noncompliant with cares and medications administration.

Medical records indicated the resident was found sitting on the floor in her bathroom, she had increased confusion, nonsensical speech, was falling in and out of sleep and hallucinating. The resident was transported to the hospital and later that day returned to the facility.

The internal investigation indicated that the emergency medical services delivered hospital paperwork to unlicensed staff #1. Unlicensed staff #1 and #2 were aware the resident had returned and failed to report to the oncoming shift or the nurse that the resident returned to the facility. When unlicensed staff #1 returned to work the following day, it was reported the resident had not returned from the hospital. Unlicensed staff #1 went to the resident's room and found the resident on the bathroom floor, lying on her left side. A nurse instructed staff to transfer the resident off the floor. After a few hours, staff reported to the nurse that the resident had pain in her left leg, and three staff transferred the resident. The resident was transported back to the hospital. The facility investigation indicated that the resident did not receive any services from the time of her return until the next day.

The resident's hospital records indicated the resident presented in the hospital's emergency department with weakness, confusion, left leg pain and a temperature of 100.4 Fahrenheit. The resident was diagnosed with Rhabdomyolysis, [a serious medical condition in which damaged skeletal muscle tissue breaks down rapidly, which can be caused by extreme exertion, prolonged immobilization] and a mild tear of the left gluteus minimus, [muscle attached from the pelvis to the femur]. Hospital staff recommended the resident was weight bearing as she could tolerate but needed physical therapy, occupational therapy, assist of two staff for transfers and a hospice referral for palliative care. The resident was discharged back to the facility approximately a week later.

During an interview, unlicensed staff #1 stated when the resident returned from the hospital the first time, communication was difficult because the facility did not have a main phone line, so there was no communication from the hospital that the resident returned to the facility. When the resident returned to the facility, unlicensed staff #2 and unlicensed staff #3 assisted the resident back to her room and into her chair. Unlicensed staff #1 recalled signing the emergency medical services document and was given the resident's hospital paperwork while in

the middle of passing medication to another resident. The resident's hospital paperwork was placed on the nurse's desk. Unlicensed staff #1 stated unlicensed staff #2 and unlicensed staff #3 were aware the resident returned to the facility that shift and unlicensed staff #2 gave a verbal end-of-shift report to the oncoming shift. Unlicensed staff #1 stated she did not learn that the resident did not receive services until she came on her shift the next day and found the resident on the floor. When the resident was found on the floor, she did not look good and was in pain, the nurse instructed staff to assist the resident into her chair. Unlicensed staff #1 stated it was not until four hours later when three unlicensed staff had difficulty lifting the resident into her chair, did the nurse instruct the unlicensed staff to call 911.

During an interview, unlicensed staff #3 stated when the resident returned from the hospital, she assisted unlicensed staff #2 with changing the resident and assisting her into bed. When the resident was found on the floor, the nurse instructed staff to obtain the resident's vital signs, assist the resident off of the floor, change the resident's clothes, offer the resident something to eat and wait a little bit to call 911 even though the resident did not look good. Unlicensed staff #3 stated later staff reported to the nurse that the resident was weak and the nurse instructed staff to call 911. Unlicensed staff #3 stated when the nurse was on the phone with emergency medical services, the emergency medical services questioned why 911 was not called as soon as the resident was discovered on the floor. Unlicensed staff #3 stated the resident was then transported to the hospital and returned to the facility a couple of days later and needed the use of a wheelchair.

During an interview, the facility nurse stated unlicensed staff #1 stated she got busy and forgot to call the nurse when the resident returned from the hospital. Unlicensed staff #2 stated he was assigned to the resident upon the resident's return to the facility and reported at the end of the shift to unlicensed staff #3 that the resident returned. Unlicensed staff #3 denied being informed of the resident's return to the facility. The facility nurse stated unlicensed staff were to follow facility policy which indicated staff to call the on-call nursing staff when a resident returns from the hospital.

During an interview, one of the resident's family members recalled a hospital nurse reported the incident to her but the family member was out of town and the hospital nurse was unable to get a hold of another family member. The family member could not recall if the hospital nurse called her after fall #1 or fall #2.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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.
Insert maltreatment definition here.

Vulnerable Adult interviewed: No. The resident was not able to be interviewed due to cognition.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility completed an internal investigation of the incident. The facility re-educated staff on policies pertaining to resident's returning from the hospital.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Anoka County Attorney
Blaine City Attorney
Blaine Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	30479		C 07/09/2026

NAME OF PROVIDER OR SUPPLIER

SOUTHERN OAKS PLACE

STREET ADDRESS, CITY, STATE, ZIP CODE

10669 ULYSSES STREET NE
BLAINE, MN 55449

(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. INITIAL COMMENTS: #HL304792646C/#HL304793309M On July 9, 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 19 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL304792646C/#HL304793309M , tag identification 2360.	0 000	Assisted Living Provider 144G. 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. The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER

SOUTHERN OAKS PLACE

STREET ADDRESS, CITY, STATE, ZIP CODE

10669 ULYSSES STREET NE
BLAINE, MN 55449

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0 000	Continued From page 1	0 000	Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, 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 one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		