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

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #: HL306362060M** **Date Concluded:** May 6, 2026
**Compliance #: HL306367710C**

**Name, Address, and County of Licensee Investigated:**
Deer Crest Senior Living
470 Hewitt Blvd
Red Wing, MN 55066
Goodhue County

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

**Evaluator's Name:** Deb Schillinger 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 treatment was not provided after a fall with injury.

**Investigative Findings and Conclusion:** The Minnesota Department of Health determined neglect was not substantiated. While the resident did have a fall with an injury which was not immediately identified, when the injury was identified the facility sought appropriate care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the hospice provider. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. The investigator observed resident and staff interactions during an onsite visit.

The resident resided in a secured assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with toileting and safety

checks every two hours in the memory care unit. The resident's assessment indicated the resident was alert to person only, used a walker for mobility and had a history of frequent falls.

A concern arose when, hours after the resident fell, an injury was found requiring hospitalization.

An incident report indicated the resident had a fall late in the afternoon before the evening meal. At the time of the fall, the resident stated she tripped over her shoe coming out of the bathroom. After the resident was assessed by the nurse, and no apparent injury was found, the nurse instructed the unlicensed caregivers to assist the resident off the floor using a mechanical lift. The resident's family, provider and hospice provider were updated.

Later the same day, the medical record indicated later unlicensed caregiver #1 assisted the resident before bed, and when removing the residents long sleeve shirt, found an injury to the resident's right arm. Unlicensed caregiver #1 notified the on-call nurse. The on-call nurse gave unlicensed caregiver #1 directions to clean and cover the area. The same note indicated the on-call nurse notified the hospice provider. The hospice nurse arrived later, and after assessment, the resident was taken to the hospital for sutures and returned to the facility with eight sutures to the injury on her right arm.

During an interview, the nurse stated she was called to assess the resident after she fell. She stated the resident complained of right hip discomfort but had no other obvious injuries. The nurse gave instructions to the unlicensed caregivers to get the resident up from the floor using a mechanical lift. The resident was in good spirits and assisted to the common area with other residents for dinner. The nurse stated she instructed the unlicensed caregivers to check for bumps or bruises later after the evening meal.

During an interview, unlicensed caregiver #1 stated while assisting the resident to get ready for bed, she removed her long-sleeved shirt she found a deep skin tear. She notified the on-call nurse who instructed her to clean the wound and cover the wound with telfa. Unlicensed caregiver #1 reported the resident stated "oh my" when she saw the injury, however, she did not complain of discomfort. The unlicensed caregiver reported no bleeding was visible on the outside of the resident's shirt.

During an interview, the hospice nurse stated she was called to make an on-call visit due to an injury found after a fall earlier the same day. She stated when she arrived, she removed the nonstick dressing from the skin tear and noted hanging tissue on her right arm that when lifted revealed vessels and adipose tissue. The hospice nurse stated the resident did not complain of discomfort during the assessment or during the manipulation of the wound. The resident was then transported to the hospital, received sutures and then returned to the facility a few hours later. The hospice nurse stated she visited the resident weeks later and stated the wound healed without incident.

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.
(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, unable due to cognitive impairment.
**Family/Responsible Party interviewed**: Yes
**Alleged Perpetrator interviewed**: Not Applicable

**Action taken by facility:** The facility notified the hospice and sent the resident to the hospital.

**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 |
|---|---|---|---|
| | 30636 | A. BUILDING: _____ B. WING _____ | C 03/31/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DEER CREST SENIOR LIVING | 470 HEWITT BOULEVARD RED WING, MN 55066 |

| (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 March 31, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL306367710C/#HL306362060M.<br><br>No correction orders are issued. | 0 000 | | |