

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL313375462M  
**Compliance #:** HL313372860C

**Date Concluded:** February 4, 2026

## **Name, Address, and County of Licensee**

### **Investigated:**

Highland Gracewood  
1925 Graham Avenue  
St. Paul, MN 55116  
Ramsey County

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

**Evaluator's Name:** Yolanda Dawson, 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 a resident when staff did not check on the resident during the night and he was found deceased in the morning.

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was not substantiated. When the resident complained of not feeling well and experienced hip pain, staff promptly notified his provider. The day before the resident's passing his provider came to the facility and assessed him. The resident completed x-rays at that time, and results were pending. The resident declined to be sent to the emergency room. Staff last encountered the resident late evening and then followed the resident's care plan not to be disturbed during the night. Staff found him unresponsive in the morning.

The investigator conducted interviews with facility staff members, nursing staff, and unlicensed staff. The investigator contacted the medical examiner and the resident's provider. The

investigation included review of the resident record, death record, provider notes, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included type 2 diabetes with nerve pain and congestive heart failure. The resident's service plan included assistance with bathing, escorts, mobility assistance, every two-hour safety checks from 7:00 a.m. to 10:00 p.m., vital signs, and blood sugar monitoring. The resident's assessment indicated the resident's behaviors were not posing a risk to self-harm. The assessment indicated decreased muscle mass and strength, reduction in mobility, chronic pain, were a risk for falls. The assessment also indicated the resident did not want to be disturbed or checked on every two hours from 10:00 p.m. to 7:00 a.m. This request was also indicated in the resident's individual abuse prevention plan.

A facility nursing policy indicated a responsible party could refuse or request less frequent safety checks, and nursing would educate them about the risks of decreased safety checks and document the education in the residents chart.

Nursing notes dated seven months before the resident's passing indicated the resident declined safety checks during the night and did not want staff entering his room between 10:00 p.m. and 7:00 a.m. The nurse she explained the importance of safety checks as a safety measure to ensure the resident was okay throughout the night. The nurse indicated the resident acknowledged understanding but still declined the check and the service agreement had been updated accordingly.

The resident's progress notes indicated two days prior to the resident's death, the resident reported he felt unwell, his legs were weak and he could barely move from his recliner chair to his bed. The nurse assessed the resident's vitals and were stable, but a lower blood pressure. The nurse encouraged the resident to use his call light to request assistance with the bathroom, encouraged fluids, would follow up on blood pressure and notified the medical provider. An hour later, the nurse rechecked the resident who then reported pain in his right hip. Staff administered oxycodone (controlled-pain medication). On a third check of the resident's blood pressure it had improved to normal limits.

The medical provider's notes indicated the resident was assessed the next day. The resident had complained of stomach pain and right hip pain when standing. The resident declined to go to the emergency room. The provider ordered medication for nausea, X-ray of the right hip and abdomen, and physical therapy evaluation. The notes indicated if the resident's pain worsened or if he was unable to stand, he should be sent to the emergency room. The provider notes and orders did not indicate continued monitoring of vital signs.

The resident's progress notes indicated the following day at 8:30 a.m., staff found the resident unresponsive on the floor and called 911. The officer pronounced the resident deceased.

The resident's death record indicated that the cause of death was from natural causes.

During an interview, nurse #1 stated two days before the incident the resident was weak, experienced hip pain, and had a low blood pressure. Because the resident had difficulty moving at that time a wheelchair was provided. Nurse #1 stated the resident was encouraged to go to the hospital on more than one occasion, however, he declined. Nurse #1 stated provider communication indicated the resident should be encouraged to drink more water to increase his blood pressure. Blood pressures taken later in the day indicated it was within normal limits. Nurse #1 stated provider orders were written the day before his passing for an X-ray of his hip. Nurse #1 stated the resident had oxycodone/acetaminophen ordered for pain. Nurse #1 stated the resident utilized his call-light the night before the incident at 11:00 p.m. when he asked for something to eat, and that was the last time staff had checked on the resident.

During an interview, nurse #2 stated the resident was alert and oriented and able to communicate his needs. Nurse #2 stated the resident did not want to be disturbed and requested staff not perform safety checks between 10:00 p.m. and 7:00 a.m. However, staff members did complete two-hour checks during daytime hours.

During an interview, an unlicensed personnel (ULP) stated on the morning of the incident she was performing her morning routine of checking residents blood glucose levels. She knocked on the resident's door three times and he did not answer. She proceeded to enter the resident's room and found him unresponsive face down on the floor in front of his recliner. The ULP called for help and another staff member came to help her. The nurse was notified and 911 was called. Staff were instructed to turn the resident over and check for vital signs. Paramedics arrived and pronounced the resident as deceased.

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, deceased.

**Family/Responsible Party interviewed:** No, resident was his own guardian, no contact information available.

**Alleged Perpetrator interviewed:** Not Applicable.

**Action taken by facility:**

The facility nurses assessed the resident when he had a change in condition, contacted the medical provider for evaluation and new orders.

**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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>31337</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/02/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HIGHLAND GW LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1925 GRAHAM AVENUE SAINT PAUL, MN 55116</b>
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(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	<p><b>Initial Comments</b></p> <p>On September 2, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL313372860C/#HL313375462M. No correction orders are issued.</p>	0 000		

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