Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL327505942M
Compliance #: HL327504060C

Date Concluded: January 20, 2026

Name, Address, and County of Licensee Investigated:
Abiitan Mill City Assisted Living
428 South 2nd Street
Minneapolis, MN 55401
Hennepin County

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

Evaluator's Name: Willette Shafer, 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 perpetrators (AP)-1 and AP-2 neglected the resident when AP-1 and AP-2 failed to check on the resident during the night and the resident was found on the floor hours later.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. AP-1 and AP-2 checked on the resident during the resident's assigned safety checks at 2:00 a.m. and 4:00 a.m. and the resident was in bed. The resident did not have any scheduled services after the 4:00 a.m. safety checks until her scheduled 11:00 a.m. medications. She was found during her morning medication administration around 11:00 a.m. on her bedroom floor. The resident did not have observed signs of a change in condition prior to staff finding her on the floor. The resident was sent to the hospital and diagnosed with a stroke.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The

investigation included review of the resident records, death record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator toured the facility and observed facility staff members providing resident services including scheduled safety checks.

The resident resided in an assisted living facility. The resident's diagnoses included unspecified convulsions, cognitive disorder, hypertension, and abnormal gait. The resident's service plan included assistance with medication management, safety checks at 2:00 a.m. and 4:00 a.m. on the night shift, and housekeeping. The resident's assessment indicated she had an abnormal gait due to muscle spasms and weakness related to a past transient ischemic attack (blockage of blood flow to the brain, warning sign for a future stroke). The resident had morning medications scheduled at 11:00 a.m. as she preferred to sleep in.

The resident's service delivery record indicated the resident received a 4:00 a.m. safety check. The service was documented as completed by AP-2 at 3:48 a.m.

The resident's medication administration record indicated the resident's morning medications were scheduled at 11:00 a.m.

The facility's internal investigation indicated the resident was found on her bedroom floor next to her bed with a blanket wrapped around her leg. The resident was breathing, speech was garbled but she was able to respond to simple questions. The resident was sent to the hospital.

The resident's progress notes indicated emergency medical services suspected a stroke due to resident's condition. The resident was last checked on at 4:00 a.m. and no concerns were noted. The facility notified the family of the incident. The resident was diagnosed with a stoke at the hospital.

The resident's death record indicated the resident died from respiratory failure due to a stroke.

During an interview, the nurse, said the day shift staff member reported she was unable to open the resident's bedroom door during medication administration, and the resident was not responding to her calls. The nurse brought a key, opened the door and they observed the resident laying on the floor between her bed and the bathroom. The nurse directed the day shift staff member to call emergency medical services. The resident was breathing and mumbling. The resident was brought to the hospital where she later passed away from a stroke. A surveillance camera was on the floor where the resident lived. She was unsure if the camera worked or what angle it was directed towards. The nurse and a member of management viewed the surveillance footage.

During an interview, a member of management-1 said she assisted with the internal investigation. She said AP-1 and AP-2 both reported they completed the resident's safety checks during the night shift. AP-1 was on orientation, and she was assigned with AP-2. Both AP-1 and

AP-2 reported they checked on the resident during the schedule 2:00 a.m. and 4:00 a.m. scheduled safety checks. Video surveillance of the floor the resident lived on showed AP-1 and AP-2 getting off the elevator shortly before 4:00 a.m. and walking towards the resident's apartment. There was no video footage of the hallway where the resident lived. AP-2 documented the resident was checked on shortly before 4:00 a.m.

During an interview, a member of management-2 said she reviewed the surveillance video with member of management-1. She said the video was only of the elevator on the floor where the resident lived. AP-1 and AP-2 were observed getting off the elevator on the resident's floor around 3:00 a.m. but she was unsure of the exact time.

During an interview, AP-1 said she was in training during the incident and AP-2 was assigned to provide her training. She said AP-2 showed her how to view resident services, provide cares, and document on services provided. AP-1 and AP-2 completed scheduled services including safety checks throughout the night. AP-1 described how they completed safety checks and documentation. She said there were no emergencies and nothing out of the ordinary during the night shift.

During an interview, AP-2 said she trained AP-1 the night before the incident occurred. She said she provided all scheduled services including the resident's 2:00 a.m. and 4:00 a.m. scheduled services. The resident was in her bed and breathing during both safety checks. AP-2 was knowledgeable about the services each one of her assigned residents received and their preferences.

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, she was deceased.
Family/Responsible Party interviewed: No, declined interview. The resident's family member said she had nothing more to add.

Alleged Perpetrator interviewed: Yes, both AP-1 and AP-2 were interviewed.

Action taken by facility:
The facility conducted an internal investigation and provided additional training after the incident.

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
	32750	A. BUILDING: _____ B. WING _____	C 01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABIITAN MILL CITY	428 SOUTH 2ND STREET MINNEAPOLIS, MN 55401

(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 January 7, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL327504060C/#HL327505942M. No correction orders are issued.	0 000		