



Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report: HL350491100M
Compliance: HL350495160C

Date Concluded: September 16, 2026

Name, Address, and County of Licensee

Investigated:

Eden Prairie Senior Living LLC
8480 Franlo Road
Eden Prairie, MN 55344
Hennepin County

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

Evaluator's Name: Julie Serbus, RN
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):

The facility neglected the resident when it transferred the resident with the assistance of one caregiver instead of two. The resident fell and required hospitalization. Additionally, the facility failed to provide showers and proper skin care which led to further skin breakdown.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility moved the resident to a different unit to accommodate transfers with assistance of two caregivers. However, the facility did not implement two-person transfer. The service delivery record failed to include services for transfer or toileting assistance. The resident fell and was hospitalized with a brain bleed requiring surgical intervention. Regarding showers, the resident's service plan included a schedule for bathing/showers, however there were multiple occasions when the resident was offered a shower but declined.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members. The investigator contacted the home care physical therapy company. The investigation included review of the resident records, hospital records, facility internal investigations, facility incident reports, personnel file, staff schedules, and related facility policy and procedures. Also, the investigator observed care and services to other residents during an onsite visit to the facility.

The resident resided in an assisted living facility and the resident's diagnoses included chronic heart conditions, dementia and arthritis related to history of bilateral knee replacements. The resident's assessment indicated the resident used equipment such as a wheelchair, a walker, and a shower chair. The assessment indicated the resident was independent with toileting, independent with transferring and required one person assistance with bathing. The resident received blood thinners for her heart condition.

An incident report indicated the resident was exiting the shower with the assistance of one caregiver. While attempting to step out of the shower the resident lost her balance and fell. The resident struck her head on the wall, bit her lip, received a skin tear and bruising to her arm. The resident was transported by emergency medical services to the emergency department for evaluation.

The resident was hospitalized for two days and treated for a subdural hemorrhage (brain bleed). The hospital records indicated the resident was discharged back to the facility.

The hospital discharge orders were faxed to the assisted living facility. The orders included a referral for physical therapy evaluation and treatment related to difficulty walking. The same orders indicated if the assisted living facility did not hear back from therapy in two days, it should contact the number listed on the discharge paperwork. Additional orders included discontinue anticoagulant (blood thinner) warfarin medication and aspirin until a follow-up appointment.

The facility's nursing assessment upon the resident's return from the hospital indicated no changes to physical devices and the assessment indicated the resident remained independent with toileting, transfers, and walking with a walker, contradictory to the hospital evaluation. The assessment indicated the resident required escort for longer distances, continued to require one-person assistance with bathing and was a fall risk.

Approximately two and half weeks after the resident's return from the hospital, progress notes indicated the resident's family expressed concern the resident required two-person assistance for transfers. The family requested the resident be moved to the dementia care unit for the increased level of assistance. The facility informed the family the resident's transfer status and level of care needs would be reassessed by the interdisciplinary team.

The next day, progress notes indicated the resident's medical provider provided an order for physical therapy and occupational therapy referral, although the facility failed to follow up for first physical therapy evaluation order by the hospital. The facility faxed the received order to a therapy provider.

The facility records lacked documentation the date the resident moved to the memory care unit. The family member stated the resident moved to the new apartment the next day (after the facility faxed the therapy order).

The resident's record lacked any further assessments or updates to the resident's service plan to support the change in needs and transfer to a memory care unit for additional assistance.

An incident report indicated the day after the resident moved to her memory care apartment, at 4:40 a.m., the resident had a witnessed fall in the living room. At the time of the incident there was one staff person present. The incident report dictated "she [the resident] reports she slid down the edge of the chair." The report indicated the caregiver described seeing the resident attempt to sit in her recliner, sat down and slid to the floor. There was no indication staff provided assistance of one (physically holding the resident).

The resident's service delivery record indicated, at the time of the fall, the resident did not have services for transfer assistance or toileting assistance.

A progress note the next day indicated the resident was transferred to the hospital after the fall with a brain bleed and required surgical intervention. The late-entry progress note indicated the nurse assessed the resident the day prior to her fall and the resident transferred/walked with an assistance of one person. Therapy had not yet completed an evaluation.

Progress notes indicated the resident discharged from the hospital and returned to the facility two weeks later.

The resident's service plan was amended on the same day and included additional services including assistance with toileting. The updated service plan had services with effective date of the day the resident moved to the memory care. It is unclear if the facility started those services on that date. The service titled "orientation to cares" indicated the resident required assistance with two staff for transfers, but there was no specific service for transfer assistance with a frequency.

The caregiver witnessed to the resident's fall failed to respond to an interview request.

During an interview, the resident's family member stated she spoke with the nurse after the resident's first hospitalization and advocated for more assistance to avoid another fall as the resident had increased troubles with walking, rising off the toileting and showering. The family member assisted the resident with showers and felt she required two staff for assistance. The

family member spoke to the manager who told her to ensure the resident received two staff assistance, she would need to move to the memory care unit and there was an open room. The family member reported when the resident moved into the memory care she was only able to walk two or three steps on her own with the walker.

During an interview, a manager stated the assisted living apartments do not offer two-person assistance. The manager stated in order to receive two-person assistance the resident would have to be living in the memory care unit.

During an interview, nurse #1, stated after the initial fall the resident returned to the facility after a hospital stay. Nurse #1 stated a family member raised concerns about the resident's ability to safely transfer and shower with the assistance of one. She requested the resident be a two person assist due to a decline related to her balance and weakness so a move to the memory care unit was arranged. The nurse stated she did not follow up with therapy after the resident returned from her first hospital visit as the nurse thought the resident was already on therapy prior to the first fall. The nurse stated the resident had not been changed to a two person assist when she moved her down to the memory care as it was a precaution per family request. Nurse #1 stated the resident moved to the memory care unit and the family was told it was necessary to wait for physical therapy and occupational therapy evaluation.

During an interview, nurse #2 stated the resident's family requested the move to the memory care unit before the resident was evaluated by physical and occupational therapy. Nurse #2 stated in the assisted living units there are no two person transfers. Nurse #2 stated nurse #1 had assessed the resident when moving into the memory care unit and nurse #1 felt the resident was safe to transfer with assist of one, however, the family felt she required assistance of two staff.

During an interview, an unlicensed caregiver stated the facility communicated services to be provided to residents via electronically via phone or the medication administration record. The unlicensed caregiver stated the resident was able to walk around her assisted living apartment with a walker, and one staff assisted with showers when the resident would allow us to give her a shower. The caregiver stated the two weeks prior to moving to the memory care unit the resident was not really walking and required more assistance.

The facilities Uniform disclosure of Assisted Living Services & Amenities (UDALSA) (describes services, supports, and amenities available at the assisted living facility) signed at the time of initial admission to the assisted living facility indicated the facility's assistive living apartments offered transfers with assistance of two staff for a short period of time until rehab or a lift is available. The document indicated residents requiring assistance from two staff for transfer would be required to reside in the dementia care unit.

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.

Vulnerable Adult interviewed: Yes.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:

The facility scheduled three showers a week and transferred with the use of a Hoyer (mechanical) lift on discharge from the second hospitalization.

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

Hennepin County Attorney

Eden Prairie City Attorney

Eden Prairie Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/16/2026
NAME OF PROVIDER OR SUPPLIER EDEN PRAIRIE SENIOR LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8480 FRANLO ROAD EDEN PRAIRIE, MN 55344		
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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. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL350495160C/HL350491100M On June 16, 2026 through June 16, 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 48 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL350495160C/HL350491100M, tag identification 1640 and 2360.	0 000	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.		
01640 SS=G	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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01640	Continued From page 1 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update the service plan and implement increased transfer assistance for one of one resident (R1) reviewed. After R1's fall with hospitalization, the licensee revised R1's service plan two weeks later, with a back-dated effective date prior to R1's fall for two staff assistance with transfers. At the time of R1's fall, there was one staff with R1, although it was unclear she provided hands-on assistance. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was	01640			

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01640	Continued From page 2 issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included atrial fibrillation (irregular, often rapid heartbeats), congestive heart failure (heart muscle unable to pump enough blood), dementia, type II diabetes, and polyarthritis related to history of bilateral knee replacements. R1's comprehensive assessment dated November 14, 2025, indicated R1 used assistive devices including wheelchair, walker, and shower chair. The same document indicated R1 was independent with toileting, needed one-person assistance for bathing, and transferred independently. R1 became short of breath and was at risk or had a history of falls. R1's hospital discharge orders dated December 11, 2025, indicated R1 was to walk as tolerated and received an order for physical therapy (PT) and skilled nursing. The same document indicated R1 had difficulty walking greater than 100 feet and required the assistance of another person or specialized equipment was needed. R1's discharge paperwork indicated if the facility has not been contacted by the therapy provider within two days of discharge, the facility should contact the selected home care agency listed on discharge document. R1's readmission assessment completed upon return to facility, dated December 11, 2025, indicated R1 was independent with toileting and transfers, required one-person assist with	01640			

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01640	Continued From page 3 bathing, assistance with mobility but inaccurately indicated R1 walked independently with a walker. R1 required escorts for longer distances and was at risk for falls. A review of R1's medical record indicated no assessments were completed after December 11, 2025, until R1 returned from her second hospital stay on January 13, 2026. R1's progress note dated December 29, 2025, at 4:18 p.m., indicated the family expressed concerns in regard to R1's functional status and believed R1 now required two-person assistance for transfers. The same document indicated the family member requested R1 move to the memory care unit based on these concerns and was informed the level of care needs would be reassessed by the interdisciplinary team for appropriate recommendations. R1's progress notes dated December 30, 2025, at 3:18 p.m., indicated the medical provider provided an order for a PT/OT referral which was faxed by the facility to a therapy provider. R1's record lacked an updated service plan to support R1's change in needs and transfer to a memory care unit. R1's service delivery record dated January 2026, indicated R1 did not have services for transfer assistance or toileting assistance. R1's incident report dated January 1, 2026, at 4:40 a.m., indicated R1 had a witnessed fall in her memory care apartment living room. At the time of the incident there was one staff person present. The incident report dictated "she [R1] reports she slid down the edge of the chair." The	01640			

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01640	Continued From page 4 report indicated the unlicensed personnel described seeing R1 attempt to sit in her recliner, sat down and slid to the floor. There was no indication staff provided assistance of one (physically holding R1). R1's progress notes dated January 2, 2026, at 1:06 p.m., indicated R1 admitted to the hospital with a diagnosis of intracranial hemorrhage and was scheduled for surgical intervention. The progress noted indicated on December 31, 2025, throughout the day prior to the fall, R1 had been assessed by nursing and was transferring/walking with the assistance of one staff without difficulty. PT/OT evaluation had not yet been completed at the time of the fall. This note indicated the family's concern and dissatisfaction related to R1 only having one staff assistance for transfers. The progress note indicated registered nurse (RN)-E had assessed R1 on December 31, 2025, as a one person assist throughout the day and also expressed PT/OT assessment was pending when the second fall occurred. R1's record lacked an updated service plan following RN-E's assessment to at least provide the physical one staff assistance for transfers. R1's Individualized Services Amendment dated January 13, 2026, at 11:41 a.m., not signed, indicated effective December 31, 2025, R1's level of care listed as moderate memory support. The same document indicated R1 was to receive the assistance of two staff for showers three times a week and assistance of two staff for all transfers. This same document indicated staff were to review the residents' service plan and to initial it to confirm understanding. This same document indicated R1 was at risk for falls and staff members were to ensure R1's walker and	01640			

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01640	Continued From page 5 pendant were within reach and assistance of two staff with all transfers. R1's service delivery record dated January 2026, indicated toileting assistance at 8:00 a.m., 8:00 p.m. and 11:00 p.m. were added to the services for staff to provided and started on January 13, 2026. During an interview on June 16, 2016, at 10:26 a.m., RN-E stated R1 was moved to memory care per family request. RN-E stated the family requested assistance of two staff for transfers and showering due to increased weakness and risk for another fall. RN-E stated physical therapy (PT) had assessed and indicated R1 was a one-person assist but could not provide a date PT assessed or provide documentation. Following an incident with a fall and hospitalization on December 9, 2025, a family member had stayed with R1 for a few days and assisted R1 with cares and showering. RN-E stated it was at this point family requested R1 be a two-person assist. RN-E stated she faxed the provider immediately for a PT/OT (occupational therapy) order. RN-E stated family was told R1 could not be a two-person assist while living on the assisted living side of the facility and they only offered two-person assist in the memory care unit. The family wanted R1 moved to ensure she had the extra assistance and R1 moved to the memory care unit prior to the PT/OT evaluation and recommendations. On June 17, 2026, family member (FM)-B stated in December of 2025, R1 experienced increased trouble with walking, rising off the toilet, and showering. FM-B stated she had a conversation with RN-E after R1 returned from hospital from her initial fall on December 9, 2025, and	01640			

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01640	Continued From page 6 advocated for more assistance for R1 to avoid another fall like had just occurred. FM-B stated she became more aware R1 required two staff when FM-B assisted R1 with showering after R1 returned from a hospitalization following a fall. FM-B stated she had also spoken with the manager to ensure R1 would receive assistance of two staff and was told R1 would not be able to receive assistance of two while living in the assisted living apartment but would have to move to memory care where assistance of two staff members could be arranged. FM-B stated the manager said there was an open room in the memory care unit, although R1 did not require dementia care, R1 could be moved for the two-person assistance. FM-B stated on December 31, 2025, family moved R1 to the memory care unit. At that time R1 was only able to walk two or three steps on her own with her walker. FM-B stated R1 had been moved into the unit for six hours when she fell. R1 was walking from the bathroom to her recliner with the assistance of one staff member when she fell, hit her head, and was hospitalized for almost two weeks with another brain bleed, which required a special procedure to stop the bleeding. During a second interview dated July 1, 2026, 9:30 a.m., RN-E stated the family's request for two staff assistance guided the facility to contact the medical provider and request an order for a PT/OT evaluation. RN-E stated on December 31, 2025, without a complete PT/OT evaluation the resident moved into memory care. The request for a PT/OT evaluation had just been faxed on December 30, 2025. RN-E stated she was not sure why staff did not follow the service plan and ask another staff to assist. RN-E stated information on caring for a resident is on their service plan. RN-E stated when a new resident	01640			

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01640	Continued From page 7 moves into memory care they also send out a text message to the staff work phones to let them know a new resident is now in the unit and to read through the service plan. RN-E stated it was possible a regional nurse made the changes to R1's service plan and only changed the service but not the effective date. RN-E stated she was unsure if she had changed the service plan to reflect two persons assist or if R1 was still listed as one at the time of the fall. The licensee's Service Plan policy dated August 1, 2021, indicated all residents receiving assisted living services will have a service plan in place. Service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences. A Service Plan means the written plan between a resident or resident's designated representative and the facility about the services which will be provided to the resident. The licensee's Uniform disclosure of Assisted Living Services & Amenities (UDALSA) dated June 8, 2023, signed at the time of initial admission to the assisted living facility indicated the facility's assistive living apartments offered transfers with assistance of two staff for a short period of time until rehab or a lift is available. The document indicated residents requiring assistance from two staff for transfer would be required to reside in the memory care unit. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640			
02360	144G.91 Subd. 8 Freedom from maltreatment	02360			

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02360	Continued From page 8 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 residents reviewed (R1) were 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			