Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL353777902M
Compliance #: HL353778422C

Date Concluded: February 20, 2026

Name, Address, and County of Licensee Investigated:
Clinique Healthcare Services
7924 June Ave N
Brooklyn Park, MN 55443
Anoka County

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

Evaluator's Name: Brandon Martfeld, 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 the resident was found entrapped in the bedrail which resulted in bruising and hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident's plan of care was followed at the time of the incident. When the resident was found on the bedrail with an injury, facility staff provided immediate assistance and contacted emergency medical services. The resident received medical treatment and returned to his baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed cares provided to the

resident and that the resident used bedrails to assist with bed mobility. In addition, the resident's bed remote was clipped in a way that was not accessible for the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included functional quadriplegia (term for complete immobility, requiring total assistance with daily living), multiple sclerosis, and stroke. The resident's service plan included assistance with dressing, grooming, incontinence care, wheelchair and mobility assistance. The resident's assessment indicated the resident had an electric bed with bedrails. The resident's assessment indicated the resident used the bedrails for repositioning and turning in bed.

An incident report indicated the resident used his bed remote to elevate the head of his bed. The resident fell to his left side coming to rest with his left arm hanging over the bedrail. The resident sustained a bruise to his left underarm and across his chest. The resident was assessed by the nurse and sent to the hospital for an evaluation.

The hospital record indicated the resident sustained bruising and had no fractures. The resident was treated for pneumonia and discharged back to the facility.

During an interview, the nurse stated the resident had been assessed to have the bedrails in place for bed mobility. The morning of the incident, an unlicensed staff member was getting clothes from the resident's closet. The resident elevated his head of the bed and tipped over to the left side onto the bedrail. The resident was in pain and had a bruise. The resident was transported to the hospital for an evaluation. When the resident returned from the hospital, the resident was reassessed, and it was determined that a different style of bedrails would be applied to the resident's bed. In addition, the bed remote would be kept out of reach of the resident.

During an interview, the resident stated he uses the bedrails for bed mobility and had no concerns with the bedrails. The resident stated he had no concerns about staff care.

During an interview, a family member stated they were aware of the incident and had no concerns with the resident's cares from facility staff.

An attempted interview was made with the unlicensed staff member that was a witness to the incident but was not successful.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Upon returning from the hospital, the resident was reassessed. A different style of bedrail was applied to his bed and the bed remote is to be placed out of reach of the resident.

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
	35377	A. BUILDING: _____ B. WING _____	C 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINIQUE HEALTHCARE SERVICES I	7924 JUNE AVENUE NORTH BROOKLYN PARK, MN 55443

(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 27, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL353777902M / HL353778422C. No correction orders are issued.	0 000		