Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL360216722M
Compliance #: HL360216043C

Date Concluded: December 17, 2025

Name, Address, and County of Licensee Investigated:
The Preserve of Roseville
2600 Dale Street North
Roseville, MN 55113
Ramsey 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 alleged perpetrator (AP) neglected the resident when the resident did not receive medication according to physician orders, resulting in dehydration and passing away.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The pharmacy delivered a bag of medications to the facility, and the AP set them down on the counter in the office area. A different unlicensed staff member picked up the bag of medications and brought them to the resident. The resident was independent with medication administration. The medication in the bag, morphine (narcotic pain medication), belonged to another resident. The resident took five pills of morphine over three days. The resident had a decline in health, but it was not related to morphine.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, hospice nursing staff, and unlicensed staff. The investigator contacted a physician.

The investigation included review of the resident records, death record, hospital records, hospice records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator made an unannounced visit to the facility.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes, gangrene (loss of blood supply causing tissue death) of the toe of the left foot, and a left foot ulcer (open sore) with necrosis (death of skin tissue). The resident's service plan included assistance with dressing, toileting, and transfers. The resident's assessment indicated the resident was cognitively intact, had hospice services to assist with medication management, and was independent with self-administering medications.

The hospital record indicated the resident admitted to the hospital approximately a week and a half prior to the incident. The resident was diagnosed with chronic left foot osteomyelitis and an amputation was recommended however the resident declined and was discharged to the facility on hospice.

Progress notes indicated the resident returned to the facility with hospice services due to osteomyelitis (bone infection) in the left foot. The progress notes indicated no changes were made to the resident's service plan and the resident continued to administer his own medications.

Approximately eight days later, a facility investigation indicated the pharmacy delivered medications in the early morning hours to the facility. Unlicensed staff member #1 accepted the medications and brought the medication into the facility's office area. The AP, an unlicensed staff member, stated she delivered the bag of medications to the resident because it had the resident's name on the bag but did not open the bag of medications. The bag of medications contained a different resident's morphine medication. Two days after the medications were delivered to the facility, the morphine medication card was removed from the resident's room and was noted to have five doses missing from the medication card. The facility offered medication management services to the resident because of concerns with the resident being able to manage his medications independently. The resident refused medication management service.

Progress notes indicated a nurse assessed the resident after the morphine medication was removed from the resident's room. The resident stated he was feeling well and had no complaints of dizziness or nausea. The resident stated he thought hospice started him on morphine for pain control and did not read the name on the morphine medication card.

Hospice notes indicated a nurse made a visit to the resident and assessed the resident was not safe to remain alone in his apartment. The resident had missed taking several days of medications and was no longer safe to take his medication independently. The resident was sent to the hospital.

Hospital records indicated after receiving the morphine the resident admitted for an altered mental status however the altered mental status did not appear to be related to morphine toxicity. The resident was provided medication for ongoing foot pain and died two days later in the hospital from necrosis of the left foot.

The resident's death certificate indicated the resident's cause of death was critical limb ischemia/necrosis, and dry gangrene of left foot.

During an interview, unlicensed staff member #1 stated she was working an overnight shift and received medications in the early morning hours from a pharmacy delivery. After receiving the medications, another resident called for assistance, and the medications were brought back into the office area and set down on a counter. Unlicensed staff member #1 stated she did not put the medications away or bring the resident his medications.

During an interview, the AP stated she worked day shift and brought the resident the bag of medications because the bag had the resident's name on it. The AP stated she did not open the bag of medications because the resident did not have medication management services and was independent with medication administration.

During an interview, a facility nurse stated the resident had services from a hospice agency and administered his own medications. Unlicensed staff member #1 received the medication from the pharmacy during the early morning hours and set the medications down on a counter in the office area. The AP picked up the medications and delivered the medication bag to the resident. The bag of medications contained another resident's morphine. Two days after the resident's medications were delivered by the pharmacy, the morphine was removed from the resident's room and was noted to have five pills missing from the medication card. The resident was not prescribed morphine at the time. The facility nurse stated the resident was assessed the morning the morphine medication was removed from the resident's room. The resident had no complaints and denied nausea, dizziness, or sleepiness. Hospice was notified that the resident had taken another resident's morphine. A hospice nurse made a visit with the resident the day the morphine was removed from his room and sent the resident to the hospital.

During an interview, hospice leadership stated a nurse would set up a weekly medication organizer for the resident. The hospice agency was alerted the resident had taken another resident's morphine. There were no concerns the resident experienced side effects from taking the morphine. There were concerns for the resident's safety related to medication administration, and that was why the resident was sent to the hospital.

During an interview, a physician stated morphine would be effective in a person for four to six hours and can cause respiratory depression. The resident's cause of death was because of gangrene and bone infection. The resident had a chronic foot infection that had been going on for months. It was recommended to the resident to have the foot/leg amputated, but the

resident chose not to have the amputation done. The resident understood there were life-threatening complications by not having the procedure completed. The infection spread throughout the resident's body and caused organ failure. The physician stated respiratory depression would happen right away to a person and not a few days later. The resident did not have respiratory depression listed as a cause of death on his death record.

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. Resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility provided education to facility staff instructing them not to accept medications for residents that do not receive medication administration services from the facility. The facility notified the pharmacy and requested that they do not deliver medications past 10:00 p.m. Audits were completed of the office area to ensure no medications were left out on the counter.

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

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ROSEVILLE'S PRESERVE	2600 DALE STREET NORTH ROSEVILLE, MN 55113

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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: HL360216722M/HL360216043C HL360215662M/HL360213280C On November 12, 2025, 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 56 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL360215662M/HL360213280C, tag identification 1620 and 2360. No correction orders are issued for HL360216722M/HL360216043C .	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.	
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 1 (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in	01620		

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01620	Continued From page 2 the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a comprehensive reassessment for one of one resident (R2) with a change in condition. Over approximately one month, R2's mobility declined to being unable to walk, required a mechanical lift, experience an infection and developed skin wounds. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was 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: R2's record indicated R2's diagnoses included dementia and encephalopathy. R2's assessment dated June 4, 2025, indicated R2 had severe cognitive impairment, required staff assistance with changing incontinence products and to report any changes of R2's skin to the nurse. The assessment indicated R2 was	01620		

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01620	Continued From page 3 independent with grooming, walking, bed mobility, transferring, and did not use a wheelchair. R2's assessment indicated R2 was a vulnerable adult and had difficulty communicating and many not report abuse or neglect. Progress note dated July 24, 2025, indicated R2 had become "less engaged" since starting risperidone twice a day. An order for risperidone to be changed to once a day was requested along with a urinalysis to rule out a urinary tract infection (UTI) was placed. The progress note was electronically signed by registered nurse (RN)-M on August 27, 2025 (a month later, while R2 was hospitalized). Progress note date July 28, 2025, indicated R2 fell on July 25, 2025. R2's fall assessment went unchanged, and no signs of injuries were noted. R2's fall incident report dated July 25, 2025, indicated the facility's nurse/supervisor was not notified of the fall. Progress note dated July 30, 2025, indicated R2 was started on an antibiotic for 10 days to treat a UTI prophylactic (intended to prevent disease). The progress note was electronically signed by RN-M on August 27, 2025 (while R2 was hospitalized). R2's service delivered record indicated on August 1, 2025, R2 was noted to have redness between her legs around her knee area. The service delivered record indicated on August 7, 2025, R2 was not able to walk. On August 8, 2025, the service delivered record indicated R2 was no long walking. On August 11, 2025, the services delivered record indicated R2 required the use of a wheelchair.	01620		

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01620	Continued From page 4 R2's record lacked evidence of nursing follow up to determine if the prophylactic antibiotic was effective. Progress note dated August 19, 2025, indicated R2 was sent to the hospital on August 16, 2025, due to altered mental status and skin breakdown. The progress note was electronically signed by RN-M on August 19, 2025. Review of R2's medical records indicated in the weeks from June 4, 2025, to August 16, 2025, R2 was diagnosed with a UTI, had medication changes, had a fall, was no longer able to walk, required a mechanical lift for transfers, and had skin integrity concerns. Although R2 was assessed after the fall R2 was not assessed for the other change in conditions and no new interventions were put in place to address acquiring infections and mobility assistance due to decline in mobility. In addition, the medical record lacked evidence that R2's primary provider was updated of the overall decline. Emergency medical service (EMS) report dated August 16, 2025, indicated R2 was found to be lying in bed. R2's skin was hot to the touch, pale, and incontinent with fecal stains on the bed sheets. R2 was lethargic and had wounds. An odor of a UTI could be noticed. The report indicated no facility staff was present in R2's room and that facility staff did not provide paperwork or R2's information to EMS staff. EMS staff made multiple attempts to locate facility staff and were told the facility staff were too busy. EMS transported R2 to the hospital. R2's hospital record dated August 16, 2025, through August 31, 2025, indicated R2 admitted to the hospital for wound management,	01620		

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01620	Continued From page 5 encephalopathy and was treated for a UTI. R2 had four wounds, left inner knee, right inner knee, right heel, and left hip. The left inner knee wound was a deep tissue injury that measured 3 x 5 centimeters (cm). The area was open, bleeding with a deep purple/black area covering about 30%. The wound was likely caused from pressing to the opposite knee. The right inner knee wound was a deep tissue injury that measured 3 x 5 cm. The wound appeared to be a ruptured blister with purple/red wound base. The right heel wound was a deep tissue injury that measured 1.5 x 2.5 cm. The wound was closed with a purple and black blister. There was faded brown rings that suggested the wound was a larger deep tissue injury. The left hip wound was an unstageable pressure injury that measured 4 x 3 cm. The wound was 50 percent covered by yellow/brown slough (dead cells, debris, and remnants of tissue that have not yet undergone proper breakdown and removal from the wound bed). The hospital record indicated the family stated in July, R2 was able to walk and talk despite her impaired cognition. The hospital record indicated "there is concern for negligence given her presentation." R2 passed away in the hospital 15 days after being admitted. R2's death record indicated R2 died August 31, 2025. R2's cause of death was failure to thrive. R2's death record indicated other significant conditions contributing to the R2's death included dementia, severe malnutrition and incidental pulmonary embolism. During an interview on November 25, 2025, unlicensed staff member (ULP)-I stated R2 started to decline and required a mechanical lift for transfers. R2 required two staff for transfers and toileting.	01620		

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01620	Continued From page 6 During an interview on December 2, 2025, a friend (FR)-L of R2 stated she visited R2 approximately five weeks prior to the hospitalization, and R2 could walk. FR-L stated the next time she came to visit R2 was a few days after July 25, 2025, when R2 fell. R2 was using a wheelchair and could not walk. On August 16, 2025, when R2 was sent to the hospital, two staff members came into R2's room to assist in getting her up for lunch. R2 had wounds to her legs, hip, and heel. FR-L stated she called R2's family member to give an update and called emergency medical services. During an interview on December 2, 2025, family member (FM)-K stated in July she visited R2 at the facility. At that time, R2 could walk and use the bathroom. FM-K stated she was not aware R2 required a mechanical lift for transfers and required a wheelchair for mobility. FM-K stated she was not aware R2 was so sick. During an interview on December 2, 2025, RN-M stated when R2 first moved into the facility in March of 2025, she was not very medically complex and required a low level of care. R2 would keep to herself in her room. Then in June, R2 began to change, R2's mood was up and down. At times R2 was happy and engaged with staff. As the summer progressed, R2 had skin breakdown on her buttocks and became incontinent of bowel and bladder. Then in July of 2025, R2 became more withdrawn and was started on an antibiotic for a UTI and required the use of compression socks for swelling in her legs. On August 16, 2025, R2 was hospitalized for altered mental status and skin breakdown. RN-M stated R2 had a change in condition assessment was completed on July 1, 2025.	01620		

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01620	Continued From page 7 During an interview on December 3, 2025, regional director of operations (RDO)-N stated on August 16, 2025, R2 had a visitor that noticed redness on her skin and wanted R2 sent to the hospital. During the facility's investigation, facility staff denied the resident had skin concerns; however, documentation dated August 1, 2025, indicated R2 had redness around her legs and between the knees. RDO-N stated the facility's expectation was that a nurse would assess the area that had redness or skin breakdown, but no documentation regarding R2's knees being assessed was found. RDO-N stated no assessment was completed after the June 4, 2025, assessment as mentioned by RN-M and no change in condition assessment was completed. RDO-N stated no communication to the provider about R2's changes could be found in the medical record. During an interview on December 3, 2025, hospital social worker (SW)-J stated R2 appeared to not be getting adequate care from the facility. A phone call was placed to the facility to get a baseline status of R2 and what changes were observed. SW-J stated she never received a phone call back from the facility. The licensee's policy titled Nursing Assessment of Assisted Living Resident dated September 2025, indicated RN will review the nursing assessment and service plan and, if necessary, will update the assessment and service plan, whenever the resident has returned from a hospital or nursing home stay, has a changing in condition or experiences an incident such as a fall. The RN will complete any needed assessment based on the change of condition of the resident, review/update the resident service	01620		

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01620	Continued From page 8 plan, review/update the resident's care plan, will communicate any changes to the resident and/or responsible party and will communicate any new problems or concerns to the resident's physician or health care providers. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01620		
02360	144G.91 Subd. 8 Freedom from maltreatment 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 resident reviewed (R2) was 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		