DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL362216064M
Compliance #: HL362214560C

Date Concluded: December 30, 2025

Name, Address, and County of Licensee Investigated:
Eagancare Behavioral Health
1766 Gabbro Trail
Eagan, MN 55122
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, 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 perpetrator (AP), a registered nurse, neglected the resident when he failed to provide medical care timely in response to the resident's illness.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had at baseline occasional vomiting and nausea. The facility staff, including the AP, encouraged and offered to aid the resident to receive a medical evaluation of her illness on the day the resident was noted to be sick. Concerned for the resident's well-being, staff called 911. Emergency medical staff (EMS) arrived at the facility and evaluated the resident. The resident declined to go with EMS to the hospital at that time. Later the same day, the resident stated she wanted staff to call 911, and the resident was transported to the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case worker. The

investigation included review of the resident records, hospital records, facility internal investigation, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident cares while on site.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder, bipolar disorder, borderline personality disorder, depression and morbid obesity. The resident's service plan included assistance with bathing, behavior management, medication administration, meal assistance, and safety checks. The resident's assessment indicated the resident was alert and oriented with forgetfulness. The assessment identified the resident as independent with toileting and walking. The assessment indicated the resident had nausea and vomiting occasionally at baseline and routinely saw a mental health professional.

A report indicated the resident had not eaten in 10 days, had vomited, and had not bathed in over a month when the resident reached out to the facility owner and expressed concerns about her health.

The resident's service delivery record indicated the resident received five showers in the month prior to the client's hospitalization, and declined staff offers to assist her with bathing 23 times.

The resident's progress notes indicated the resident felt nauseous and threw up, eight days prior to her hospitalization. The next day, the notes indicated the resident took all her medications, was awake all night and was doing ok. The following day, the resident took her medications and requested her vape pen from staff. The following day, the resident took her medications and ate food that she ordered and had delivered to the facility. The next day, the resident attended a physical therapy appointment, returned to the facility, took her medications and ate scheduled meals.

Progress notes indicated the next day, four days prior to her hospitalization, the resident stated she was tired and spent most of the day in bed. The next day, the resident declined her morning medications stating she was going to the fair, and she could not take the medications when in the sun. The resident left the facility for 12 hours to attend the state fair. The notes indicated the resident refused her medication upon return to the facility. The next day, the notes indicated the resident stated she was not feeling well, and staff checked the resident's blood pressure, cooked the resident her requested meal, and consistently checked on her.

Progress notes indicated the next day, the resident stated to staff she had not felt well since the day prior, upon her return from the fair, and staff offered to call 911 for the resident, who adamantly stated she did not want to go to the hospital. The day before her hospitalization, the notes indicated the resident refused her morning medications, attended a doctor's appointment, and refused her medication upon her return to the facility from the appointment. That night, the notes indicated the resident had been upset with staff for waking her up to take medication, and she did not want any medication. The notes indicated unlicensed personnel

(ULP)-1 called 911 to have the resident assessed, and the resident refused to go to the hospital with emergency medical services at that time. The following morning, the notes indicated the resident declined to attend her group meeting and requested ULP-1 lock her door so nobody could disturb her. ULP-1 offered again for the resident to go to the hospital, in which the resident declined. The notes indicated the resident attended a virtual appointment in her room with her mental health provider and then requested to go to the hospital. The notes indicated staff called 911 after the resident received a shower, per her request, and was transported to the hospital.

The resident's hospital records indicated the resident presented to the emergency room with ongoing nausea, vomiting and constipation of one week. The record indicated there were no findings to explain the resident's symptoms as blood cultures had no growth, urine cultures were negative, and the CT (computed topography) scan was negative for abdominal pathology. The record indicated the resident had over 50 medications listed on her home medication list that could have caused gastrointestinal side effects. The record indicated the resident returned to the facility after three days at the hospital.

During an interview, ULP-1 stated staff checked on resident's at least every two hours. ULP-1 stated if a resident was sick, the first thing caregivers did was take the resident's vitals, then informed the nurse for further directive that may include calling 911. ULP-1 stated the resident required assistance with bathing and sometimes needed assist with toileting. ULP-1 stated the client was not compliant with her bathing plan of care, as she cancelled her showers most of the time. ULP-1 stated the resident had never gone without a shower for month or longer. ULP-1 stated the resident was only noticeably ill the day she went to the hospital. ULP-1 stated he notified the AP who directed him to take the resident's vital signs and call 911. ULP-1 stated when EMS arrived, the resident declined to go with them to the hospital.

During an interview, ULP-2 stated she went to appointments with the resident, or the resident went by herself depending on how she felt. ULP-2 stated the resident was not always compliant with her cares, and staff tried multiple times to convince the resident to complete the task she. If she refused, they documented the refusal and notified the nurse. ULP-2 stated the resident mostly refused showers but never gone a month without a shower. ULP-2 stated the resident did not sleep well and was awake most nights, and slept the whole day, which made it hard for the resident to eat routinely and take her medications. ULP-2 stated the resident was not sick the day prior to her hospitalization but had refused her medications the days prior. ULP-2 stated staff had checked on the resident, took her vital signs, and notified her the resident had thrown up and stated she was not feeling well. ULP-2 stated staff told her the resident stated she just wanted to be left alone to sleep because she was tired. ULP-2 stated staff asked the resident if she wanted to go to the hospital, and she said no. ULP-2 stated staff called 911 anyway, and the resident declined to go with them to the hospital.

During an interview, the AP stated staff are trained to notify the facility coordinator or to call him directly to let him know if a resident was not eating, drinking or using the bathroom per

their normal. The AP stated he then followed up with the resident to verify and then communicated to the resident's care team for recommendations for either an appointment or if a call to 911 needed to be made. The AP stated the resident was not compliant with her care and had left the hospital against medical advice before. The AP stated there was clear interventions in the computer system for staff to attempt when the resident refused cares. The AP stated it had been a struggle to get the resident to be compliant with showers as the resident would state she would do it later, and when later came, she declined. The AP stated the facility held meetings with the resident and asked her what they could do to make her shower compliance better, and the resident stated she was working on it with her therapist. The AP stated the resident had never gone a month or longer without a shower. The AP stated the resident had never voiced specific complaints to him, except for when she stated the staff did not try hard enough to wake her up to take her medications. The AP stated the facility had attempted to change the resident's medication administration schedule to better fit her abnormal sleep schedule, but the resident declined to change her medication times. The AP stated he received a call from staff who notified him the resident had thrown up and declined her medications. The AP stated he then called the resident and asked her why she did not want to take her medications, and the resident stated she did not feel well. The AP stated the resident's vital signs were normal, and there was nothing going on out of the ordinary for the resident. The AP stated he told the resident if she did not feel well, she should go to the hospital, and the resident stated if she went in, she would just sit there for hours and they would not do anything for her, so she did not want to go to the hospital. The AP stated the resident had not been sick leading up to that day.

During an interview, a registered nurse (RN) stated staff notified her if there was a change in the condition of a resident. The RN stated staff reapproached a resident two to three times if they refused medications or care, in attempt to get the resident to accept the care. The RN stated if a refusal pattern is noted, she called the provider of the resident to notify them and see if they wanted to make any changes. The RN stated the resident was sometimes complaint with her care and sometimes was not. The RN stated she educated and explained to the resident the importance of taking her medications and showers, and the resident stated she would do it, but then did not. The RN stated the resident had never gone a month without a shower. The RN stated she recalled the resident stating she was nauseous and refused her medications due to being tired for two to three days prior to her hospitalization. The RN stated the resident threw up and said she was not feeling good during her mental health therapy session, so staff called 911. The RN stated the resident refused to go to the hospital with EMS at that time, but did go to the hospital later that evening after the resident spoke with the AP.

During an interview, the resident's case manager stated the resident became irritable and defiant when it came to following recommendations from her primary care provider or facility staff when she had mental health symptoms present. The case manager stated the resident was compliant with her care. The case manager stated the resident had not taken a shower for three to four weeks, and the resident was good about communicating that she had not taken a shower yet. The case manager stated facility staff treated the resident like family more than a

resident in a caring way, and that hindered the care and services they should have provided. The case manager stated the resident had not been feeling good for weeks prior to her hospitalization, and the AP and ULP-2 were made aware of that in a meeting they had together with the resident three weeks prior. The case manager stated the resident was very good at advocating for herself, and she voiced many concerns that she felt had not been addressed by the AP.

During an interview, the resident stated the AP did not know she had not felt well until she texted him and he directed her to go to the hospital. The resident stated she did not know how ULP-2 could not have known she was sick because ULP-2 was at the facility every day. The resident stated the AP and RN were great; they were like family to her. The resident stated she laid on her side and faced the wall for three weeks throwing up and had diarrhea, so she did not understand how the staff did not know she was sick. The resident stated ULP-1, and two other caregivers were really on top of her illness and were worried about her. The resident stated she had to give staff the okay to call 911, and she finally did.

During an interview, the resident's therapist stated the resident told her during a visit with the resident at the hospital she had not had a shower in over a month, and she told the AP for days that she was sick, and he did nothing. The therapist stated she saw the resident in person approximately nine days prior to her hospitalization during an in-person group therapy session and the resident mentioned she was not feeling that well but could not recall if the resident stated any specifics for that statement. The therapist stated she then saw the resident six days prior to the resident's hospitalization during a virtual appointment with the resident, and there did not appear to be anything out of the ordinary with the resident that day. The therapist stated she believed the resident was safe at the facility, and she believed her care needs were met at the facility.

During an interview, a family member stated the resident had brought up concerns about her care in the past that included issues with her medications, getting turned down when she asked staff for food, and that staff had not been attentive to her needs. The family member stated she believed the resident was compliant with her care, but she did not talk to the resident about if she had showers. The family member stated she believed the resident took care of herself and that hygiene was important to the resident. The family member stated the facility had never reached out to her regarding any concerns they had, except for one video phone call meeting she participated in. The family member stated she witnessed the resident struggle to advocate for herself during the meeting and just agreed to whatever the facility staff said. The family member stated the resident notified her she was not feeling well, and she told the resident to call someone. The family member stated the resident said no, they do not care. The family member stated she felt the resident was safe at the facility, and the resident's care needs were met in a mediocre fashion.

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: Yes.

Action taken by facility:
The facility offered to send the resident to the hospital when she was not feeling well and eventually she went to be evaluated.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: ______ B. WING ______	C **12/02/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	**1766 GABBRO TRAIL** **EAGAN, MN 55122**

(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 December 2, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL362214560C/#HL362216064M. No correction orders are issued.	0 000		