Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL366512082M
Compliance #: HL366513588C

Date Concluded: June 6, 2025

Name, Address, and County of Licensee Investigated:

Lexington Pointe Senior Living
3385 Discovery Road
Eagan, MN 55121
Dakota 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), a facility staff member neglected the resident when the resident fell during a transfer, which resulted in a tibia (shinbone) fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the AP was present during the fall, the resident self-transferred from a chair according to the resident's care plan when the fall occurred. The AP assisted the resident to the ground when the resident became off balance. It was determined the fall was an unforeseen event. After the fall, the resident was transported to a hospital for an evaluation.

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 incident reports, personnel files, staff schedules, and related facility

policy and procedures. Also, the investigator observed interactions between the staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease, arthritis, and osteoporosis (a condition that weakens bones, making them more likely to break). The resident's service plan indicated the resident used a walker when walking and with transfers and a wheelchair for longer distances. The resident's assessment indicated the resident was a fall risk and had impaired cognition.

The facility investigation indicated during a self-transfer, the resident lost her balance and fell backwards. The AP removed the wheelchair, got behind the resident, and guided the resident to the floor. The AP immediately reported the fall to nursing. After the fall, the resident had pain in her leg and was unable to bend her knee. Facility staff arranged for the resident to be evaluated at a hospital.

Hospital records indicated the resident presented to the emergency room for an evaluation of an injury after a fall. The resident complained of pain in the left hip and thigh area. An x-ray was completed and showed no signs of an acute (sudden) fracture. A magnetic resonance imaging (MRI) was completed to evaluate for an occult fracture (a fracture that can be difficult to see on conventional imaging due to various factors). The MRI revealed the resident sustained a knee injury and a left tibia fracture. The fracture did not require surgery. The resident was hospitalized for five days and was transferred to a higher level of care.

During an interview, the AP stated she entered the resident's apartment, asked the resident if she wanted to join an activity and the resident agreed. The bedside table in front of the resident was removed and the resident's wheelchair was positioned in front of the resident. The resident used her walker to stand up and pivoted 180 degrees. Once pivoted the resident looked back over her shoulder, tripped and fell backwards. The AP stated she attempted to guide the resident to the floor. The resident landed on her butt, with her legs straight out and knees slightly elevated. Once the resident was on the floor, other staff were alerted for assistance with the resident.

During an interview, nursing leadership stated the resident used a walker to stand and walk from her recliner to her bathroom. The resident required a wheelchair for longer distances. After the resident fell, emergency services were notified, and the resident was transported to the hospital for an evaluation. The resident was transferred to a higher level of care.

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. The resident no longer resided at the facility.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
After the resident fell, the facility notified emergency services and had the resident transported to the hospital for an evaluation.

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
	36651	A. BUILDING: _____ B. WING _____	C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON POINTE SENIOR LIVING	3385 DISCOVERY ROAD EAGAN, MN 55121

(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 May 28, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL366512082M/#HL366513588C. No correction orders are issued.	0 000		