

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL366519562M

Date Concluded: June 15, 2026

Compliance #: HL366513900C

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: Michele Larson, RN
Special Investigator

Finding: Substantiated, individual 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):

A facility staff member/alleged perpetrator (AP) failed to follow the resident's care plan and the resident fell and sustained a fracture.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to follow the resident's care plan and the resident fell and sustained an orbital fracture and fracture of the left thumb.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The AP was interviewed. The investigator contacted the resident's family member. The investigation included review of resident's records, the AP's personnel file, facility's policies and procedures, incident reports, and the resident's external medical record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's assessment indicated she was alert but forgetful and was at risk for falls. The resident's service plan included assistance of two staff and a gait belt for toileting and transfers during the morning and evening shifts and staff assistance of one while in bed during the overnight shift. The resident used a wheelchair for mobility. The resident's service plan included for staff to check and change the resident in bed during the nighttime scheduled toileting services.

The resident's medical record indicated staff was taking the resident to the bathroom in the wheelchair when she fell face forward out of the chair and hit the right side of her face and head on the floor. The resident's right cheek and right side of face immediately swelled up and her right [eye] was closed shut and she was bleeding. The resident was sent to the emergency room via ambulance for further evaluation.

The resident's hospital record indicated the resident was diagnosed with a fracture of her right orbital floor bone (thin bone forming the lower bottom of right eye socket) and a fractured left thumb.

Administrative nursing staff completed an investigation into the incident and identified the care plan was not followed at the time of the incident.

Review of the AP's employee file indicated the AP had previous disciplinary action for failing to follow the service plan when transferring a resident to the bathroom.

When interviewed, facility nursing staff indicated they investigated the incident and interviewed the AP. The AP acknowledged the care plan was not followed and when told this was a serious incident, the AP stated, "I know, I know" but could not explain why the plan of care was not followed. Nursing staff stated the AP was terminated and all staff were re-educated following the incident.

When interviewed, the resident's family member stated the AP appeared to not know what to do when he called to tell her the resident fell. The family member stated she asked the AP why the resident always fell whenever he worked, stating the AP did not have an answer.

When interviewed, the AP stated he rushed to get the resident toileted because there was another resident wandering in the hall. The AP stated he was told by the nurse to change the resident in bed because she was a high fall risk, but he did not know why he did not use a gait belt or change the resident in bed that night. The AP stated the resident's family member was "really upset" when he called to tell them the resident fell, stating the family member said it always happened on his shift. The AP stated everything would have been "fine" if he changed the resident in her bed instead of taking her to the bathroom.

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: No. The resident was deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility re-educated staff on the importance of following resident's care plans.

Action taken by the Minnesota Department of Health:

The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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>

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Dakota County Attorney

Eagan City Attorney

Eagan Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36651	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/27/2026
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NAME OF PROVIDER OR SUPPLIER LEXINGTON POINTE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 3385 DISCOVERY ROAD EAGAN, MN 55121
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(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
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order is issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL366513900C/#HL366519562M</p> <p>On March 27, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 190 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for #HL366513900C/#HL366519562M, tag identification 2360.</p>	0 000	<p>Assisted Living Provider 144G.</p> <p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

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02360	Continued From page 1	02360		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p>	02360		