



Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL371223567M
Compliance #: HL371223105C

Date Concluded: September 22, 2026

Name, Address, and County of Licensee

Investigated:

Friendship Village of Bloomington
8130 Highwood Dr
Bloomington, MN 55438
Hennepin County

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

Evaluator's Name: Heather Beigel, 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 facility neglected the resident when the resident sustained an unexplained femur fracture requiring hospitalization and surgical intervention.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The cause of the residents' injuries remained unknown and there were no unwitnessed falls. The facility took appropriate steps to update the medical provider and seek emergency care.

The investigator conducted interviews with facility staff members, including administrative staff, unlicensed staff and a family member. The investigation included review of the resident records, facility internal investigation, facility incident reports, staff schedules, related facility policy and procedures. Also, the investigator observed staff and resident interactions while on site.

The resident resided in an assisted living memory care unit. The resident had a diagnosis of Alzheimer's disease. The resident's service plan included assistance with toileting, incontinence care, and medication administration. The resident's assessment indicated moderate memory loss, disorientation and impaired decision making.

A review of medical records indicated the resident had a fall resulting in an approximate six-week transitional care stay from a right femur fracture. The resident recovered surgical intervention and upon return to the facility additional fall interventions and increased care services were implemented.

Approximately 2 days after returning to the facility an incident report indicated the resident had a fall. The facility nurse assessed the resident and found a skin tear to right elbow, and bruising to right knee. New fall prevention interventions were put in place.

Approximately 7 days after the fall the facility internal investigation indicated that the resident was found at 3:00 a.m. in the morning restless and pacing in his room. An unlicensed caregiver assisted the resident to the common living room and into a chair for better supervision. Unlicensed night staff reported that the residents appeared to be comfortably sleeping on and off until the end of their shift at six o'clock in the morning.

A progress note indicated that unlicensed day staff reported the resident was yelling out in pain around 6:40 a.m. in the morning. The resident was given prescribed as needed pain medication Robaxin. A licensed staff member stated that the Robaxin appeared to be effective, and the resident fell to sleep. The resident received scheduled Tylenol around 7:15 a.m. Another licensed staff member reported when she arrived around 7:30 a.m. that morning the resident was leaning to their right side, had ice on the left hip and was screaming in pain. A progress note indicated that the resident transferred with assist of two from chair into wheelchair then ate breakfast. The resident was then escorted via wheelchair to his room around 10:00am, transferred into bed with assist of three where incontinent cares were provided, and the resident began to yell as staff turned him. A licensed staff contacted the physician while an unlicensed staff member stayed with resident. At approximately noon the physician responded to the licensed staff member and gave orders to send resident emergency room for uncontrolled pain. Emergency services were called, and the resident went to the hospital.

During the interview, the unlicensed staff assigned to care for the resident stated she arrived for her shift at 6:30am. The resident was sitting in the common area in a chair which was unusual, he was dressed and screaming in pain. The resident could not communicate where the pain was or what caused the pain. Staff were with the resident, and the unlicensed staff started her scheduled tasks. Later that morning the unlicensed staff was asked by licensed staff to stay with the resident who was already in bed. The resident then needed incontinence care and as unlicensed staff were turning resident he started screaming in pain. Unlicensed staff noticed that there was a large, dark purple bruise on the left hip and called the licensed staff.

During an interview, the facility nurse stated the resident had a fall in months prior that resulted in a fractured right femur and a stay for rehabilitation. Upon returning resident had another fall with no injuries, a fall investigation and interventions were completed. Nurse manager stated that an internal investigation on the left femur fracture was completed, however there was no determination as to the cause of injury.

During an interview, a family member stated that they were happy with the care that their father received and did not believe the facility neglected the resident.

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, deceased

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

The facility gave pain medication and called emergency services.

Action taken by the Minnesota Department of Health:

No action taken

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: 37122	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/29/2026
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP VILLAGE BLOOMINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 8130 HIGHWOOD DRIVE BLOOMINGTON, MN 55438			
(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 July 29, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL371223105C/HL371223567M. No correction orders are issued.	0 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE