Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report: HL378503104M
Compliance: HL378501817C

Date Concluded: July 16, 2026

Name, Address, and County of Licensee Investigated:
Norbella Senior Living Savage
14275 Joppa Ave S
Savage, MN 55378
Scott County

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

Evaluator's Name: Lena Gangestad, 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 had an unwitnessed fall and was found lying on the floor, unconscious, with difficulty breathing.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The resident was not assessed as a high fall risk, was independent with ambulation using a walker, had no scheduled safety checks according to the service agreement, and had not experienced a fall in approximately two years. Upon finding the resident on the floor, the staff members took appropriate steps by calling 911 and contacting the triage nurse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, internal investigation documentation, incident reports, staff schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia. The assessment indicated the resident has impaired cognition, used a walker for ambulation and used a halo (device attached to the bed) for bed mobility. The service plan did not include safety checks.

A concern arose when the resident was found lying on the floor around 7 a.m., unconscious and having difficulty breathing.

An incident report indicated the resident was found on the floor. The same document indicated there were no visible injuries, however the resident could not related what had occurred. The facility called 911 and the resident was transferred to the hospital. The incident report indicated a caregiver had checked on the resident at approximately 4:30 a.m. over the night shift and, at the time, she was sleeping in bed. The next time a caregiver entered the resident's room was at 7:00 a.m.

The hospital record indicated the resident was not able to follow command but could move all extremities. The resident had an injury to the face causing bruising and swelling with eyes were fixed to the right. Brain imagining showed a large, recent hematoma (pool of blood) deep in the right side of the brain and it was determined surgery would not help the resident, so the focus became how to keep the resident comfortable. The resident passed away in the hospital shortly after.

During an interview, a manager, who was also a nurse, stated the resident's service plan included lower extremity wraps at approximately 8:00 p.m. on the evening before the incident. While there were no scheduled safety checks, staff routinely observed the resident during the night. She also stated the resident independently used a walker and had no acute illness.

During an interview, unlicensed caregiver #1 stated she arrived for work and prepared the resident's medications. When she went to the resident's room, she found her lying on the floor next to the bed. The resident was unresponsive, so she immediately called 911. She asked another staff member to remain with the resident and contacted triage after calling 911. Emergency responders arrived while she was still on the phone with triage. She further stated the resident independently used a walker, was stable on her feet, and regularly went on walks with family members. She said the resident was not on safety checks and was not considered a fall risk.

During an interview, unlicensed caregiver #2 stated she primarily worked overnight shifts. She said the resident had previously been scheduled for toileting assistance and safety checks. Initially, the arrangement worked well, but the resident later complained about staff entering her room during the night and waking her. As a result, those services were discontinued some time ago. She stated no medications or safety checks were scheduled overnight; however, she still checked on the resident after arriving for her shift at approximately 11:30 p.m.

During an interview, unlicensed caregiver #3 stated she was not working on the day of the incident but knew the resident well. She said the resident used a walker, moved around independently, and was stable on her feet. She stated the resident generally did not call for assistance but would approach staff if she needed anything.

During an interview, a family member stated she received a phone call and went to the hospital. She said the resident's eyes and ears were severely swollen. The family member stated the resident lived in memory care due to short-term memory loss but remained very mobile and independently used a rolling walker. She stated she was with the resident the night before and took her for a walk outside. She said the resident was in good spirits. A family member said the resident could tell you about her day and was fully active. The family member also said the resident could communicate her needs, dress herself independently, and usually received evening medications and leg wraps around 8:00 p.m. before bedtime. She stated the resident's most recent fall occurred two years earlier, which led to the move into the assisted living facility.

During an interview, the activity director stated she had worked with the resident previously. She described the resident as outgoing and sociable. She said the resident independently used a walker, remained very mobile, and communicated her needs, although she could be somewhat forgetful. The activity director also stated residents in memory care generally did not have call lights because many were unable to use them effectively. She said no known history of falls before the incident and stated the resident was frequently present in common areas.

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 was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: Staff members discovered the resident on the floor. They immediately called 911, provided appropriate care, and followed the resident's care plan.

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
	37850	A. BUILDING: _____ B. WING _____	C 06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORBELLA SENIOR LIVING SAVAGE	14275 JOPPA AVENUE SAVAGE, MN 55378

(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 June 8, 2026, the Minnesota Department of Health initiated an investigation of complaints #HL378503104M/HL378501817C. No correction orders are issued.	0 000		