Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL379276282M
Compliance #: HL379275020C

Date Concluded: December 9, 2025

Name, Address, and County of Licensee Investigated:
NG&NG Services Group LLC
8615 Birch Blvd.
Inver Grove Heights, MN 55076
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Michele Larson, 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 staff neglected a resident when they failed to recognize a resident's significant decline over several days and failed to update the resident's family about the resident's decline. In addition, the facility did not ensure the resident drank adequate amount of fluids. The resident was transported to the emergency room and diagnosed with an unknown infection and dehydration.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident's plan of care was being followed during the time the resident experienced a decline. The resident had several chronic illnesses including terminal cancer and had multiple emergency room (ER) and hospital visits during his last month at the facility. Each time staff informed the resident's provider of any changes, and updated family members in a timely manner. The resident drank adequate fluids, and his urine output record indicated his output was within normal limits.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's case manager and family member. The investigation included review of the resident record, death record, hospital record, home health record, medical provider's record, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions during the onsite investigation.

The resident resided in an assisted living facility. The resident's diagnoses included acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), dementia, and metastatic cancer.

The residents medical record indicated the resident had two nephrostomy tubes (surgically inserted tubes in the kidneys to drain urine to a urine collecting bag outside the body), and a colostomy bag (a pouch on the outside of the body that collects waste from a surgical opening in the stomach). The resident had chronic wounds on multiple areas of his body.

The resident received assistance with walking, transfers, and cares for his nephrostomy tubes and colostomy bag. The resident frequently refused cares, and staff were directed to reapproach and encourage as needed. The resident would occasionally remove his colostomy bag or pull out a nephrostomy tube which required reinsertion at the hospital. The resident was alerted and oriented and able to make his needs known. The resident was at risk for falls due to weakness and used a manual wheelchair and walker for mobility. The resident received home health services for his chronic wounds, physical therapy (PT), and occupational therapy (OT).

Review of the resident's records indicated within 30 days of his last hospitalization the resident was seen multiple times in the emergency department or hospitalized due to issues surrounding his nephrostomy tube including an addition of another nephrostomy tube inserted in his right kidney.

The resident's facility progress note indicated on the first day of the month, the resident declined all meals but drank water, juice, and protein shakes facility staff gave to the resident.

The resident's home health record indicated on the second day the resident refused to participate in his physical therapy session. The resident stated he was "Dying and is ready to go." The home health note indicated facility staff stated the resident refused to eat the past three days.

The resident's medical provider's note indicated on the second day, the resident's home health nurse sent a communication note to the medical provider indicating facility staff informed them the resident drank fluids but had no appetite.

On the fourth day, facility staff contacted the facility nurse after staff observed urine leaking out from the resident's right nephrostomy tube during morning cares. The facility nurse advised staff to call the resident's family member per the family's members request. The resident's family member arrived at 11:50 a.m. and drove the resident to the hospital.

The resident's hospital record indicated the resident's right nephrostomy tube was plugged. Imaging showed the resident's cancer metastasized to his reproductive system, bladder wall, lymph nodes, stomach lining, and lung bases. In addition, imaging revealed internal urine buildup around the upper portion of the resident's right kidney despite the presence of the resident's nephrostomy tube. The resident's right and left nephrostomy tubes were changed. Six hours later the resident's family member drove the resident back to the facility after the resident's discharge from the hospital.

On the fifth day the resident ate breakfast, drank four bottles of a nutritional supplement, ate breakfast with staff assistance, but refused lunch and dinner.

On the seventh day staff observed the resident's legs appeared weak and required assistance from two staff for transfers. The facility nurse was notified.

On the eighth day, the resident's home health nurse performed wound care and the resident's physical therapist arrived to conduct a routine visit but was unable due to the resident's refusal to participate. At 5:30 p.m., the resident's family member visited the resident.

On the ninth day at 6:54 a.m., overnight staff were unable to transfer the resident from his bed due to the resident's weak legs and the inability to straighten them. The house manager and nurse were updated as well as the resident's family members. The resident's family members reported they would bring the resident to see his medical provider to discuss obtaining a mechanical lift (Hoyer) to assist staff with transferring the resident. At 9:45 a.m., the resident's family called and told the facility the resident's appointment was rescheduled and instead they would arrive in 30 minutes to drive the resident to the hospital. At 10:30 a.m., the resident's family members arrived and told staff they would transfer the resident from his bed to wheelchair themselves but after 15 minutes requested staff assistance. After unsuccessful attempts to transfer the resident, the resident's family members agreed to allow the facility to call 911. First responders arrived at the facility within minutes and transported the resident to the hospital.

The resident's hospital record indicated the resident was diagnosed with a urinary tract infection and a dislodged nephrostomy tube. The resident was administered antibiotics. The resident's family members did not want the resident's dislodged nephrostomy tube replaced and opted for comfort cares only with a plan to discharge the resident to the family member's home under hospice care. On the 17th day, the resident died.

Review of the resident's facility urine output record indicated the resident's average daily urine output was 1,100 milliliters (mL) per day (Normal urine output for an adult is between 800 mL and 2, 000 mL per day).

During an interview, the facility nurse stated the resident refused cares and stated the resident's medical provider was always updated regarding the resident's refusals. The nurse stated the resident's family managed everything, stating anytime the resident needed to go to the ER family members wanted to make that determination. The nurse stated the facility was unable to send the resident to the ER unless they called the resident's family member to take the resident stating the family members drove the resident most times except when the resident passed a blood clot through his nephrostomy tube early one morning and the resident's family member was unable to take the resident to the hospital until hours later.

During an interview, facility leadership stated the resident pulled out his nephrostomy tubes all the time stating the resident was always weaker whenever he left the hospital. Leadership stated the resident's family member insisted on taking the resident to the hospital because she was the resident's guardian, stating the resident's family members told the facility to call them first and not 911 because the family members wanted to drive the resident to the hospital.

During an interview, the resident's family member stated the resident was "really going downhill" the previous two weeks before he died. The family member stated she drove the resident to his appointments, emergency room, and hospital visits because it was quality time with the resident, stating a lot of times she drove the resident to the hospital to have his nephrostomy tubes replaced.

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 is deceased.
Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
The facility sent the resident to the hospital numerous times and updated the resident's family member and provider.

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
	37927	A. BUILDING: _____ B. WING _____	C 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NG&NG SERVICES GROUP LLC	8615 BIRCH BOULEVARD INVER GROVE HEIGHTS, MN 55076

(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 October 29, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL379275020C/#HL379276282M. No correction orders are issued.	0 000		