Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL389811000M
Compliance #: HL389814960C

Date Concluded: August 12, 2026

Name, Address, and County of Licensee Investigated:
Freemont Village Senior Living
26369 2nd Street East
Zimmerman, MN 55398
Sherburne 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):
The facility neglected a resident when they failed to obtain timely medical care for the resident after the resident's family reported concerns the resident was having a stroke.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The alleged perpetrator (AP) was responsible for the maltreatment. The AP, a facility triage registered nurse, failed to recognize stroke symptoms when the resident's family members reported to facility staff the resident had new increased confusion and slurred speech during a phone call with the resident. The AP failed to assess the resident herself and differed inappropriately assessment to an unlicensed staff. The AP directed for the resident to be monitored until a facility nurse would report onsite the next day to assess her. Hours after the resident's family members first reported the resident's stroke symptoms, and at the family's request, 911 was called and emergency medical services (EMS) transported the resident to the hospital where she was diagnosed with an acute ischemic stroke (a medical emergency where a blocked blood

vessel stops vital blood flow and oxygen to a part of the brain). Failure by facility staff to initiate appropriate care in a timely fashion delayed emergency medical care for several hours. As a result of the delay from the first onset of a change in condition to the time the resident was finally seen in the emergency department, time sensitive treatment options were no longer available to the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family members. The investigation included review of the resident facility record, hospital record, in-house provider record, on-call triage nurse notes, ambulance run report, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed direct cares between staff and residents during the onsite investigation.

The resident resided in an assisted living facility. The resident's diagnoses included dementia. The resident's service plan included assistance with showering, laundry, and medication administration. The resident's assessment indicated she was able to be understood and made her needs known. The resident's individual abuse prevention plan indicated the resident had no decreased strength, endurance, limited range of motion or pain that restricted her physical activity. The resident walked independently using a walker. The resident's record indicated the resident wanted full life sustaining medical care necessary to sustain the resident's life.

One Sunday morning, the resident's family member contacted the facility after they observed the resident had new-onset slurred speech and increased confusion during a phone call with the resident. A facility unlicensed staff member told the family member the facility did not have an onsite nurse during the weekends, only on-call triage nurses.

Review of the on-call triage nurse notes indicated at 1:50 p.m., a medical provider's nurse reported to the AP the resident's family members were concerned the resident's symptoms were "not normal" for the resident. The provider's nurse stated the family member wondered if the resident was having a stroke and the resident's family member would like the resident to be evaluated in the emergency room (ER). The provider's nurse also reported she received an as needed medication for dizziness at 10:11 a.m. and had not used it for two months prior. The AP indicated she would perform a stroke assessment. At 1:59 p.m., the AP called the facility unlicensed staff member who was assigned to provide the resident's cares and requested the unlicensed staff member assess the resident for signs of a stroke. Verbally over the phone, the unlicensed staff member reported the resident's speech was clear and at baseline, her smile was even and she was able to raise both arms and right leg on command. The unlicensed staff member reported although the resident appeared to walk at a slower pace she "walked good," and refused lunch. At 2:10 p.m., the resident slipped and fell in her kitchen. The resident stated she had pain at the top of her right head but denied dizziness, headache, nausea, shortness of breath, vision changes, or hearing sensitivity. The AP instructed staff to check the resident once every hour for two hours, then every two hours until the following morning when a facility nurse would be at the facility to assess the resident. In addition, the AP advised staff to apply

ice to the resident's head for 15-20 minutes and administer as needed over the counter pain medication. Increased fall precautions were implemented with a possible increase in services. At 2:36 p.m., the provider's nurse reported the resident's family members wanted the resident to be sent to the ER. The provider's nurse indicated the resident's symptoms may be due to a urinary tract infection (UTI), her fall with a head strike, or stroke-like symptoms. At 2:41 p.m., the AP requested the unlicensed staff member to call 911. At 3:14 p.m., EMS picked up the resident to transport her to a local hospital but instead transported the resident to a hospital with specialized stroke services for further evaluation and treatment due to the resident's stroke-like symptoms.

Review of the resident's ambulance run report indicated at 2:49 p.m., an ambulance was dispatched to the facility. Upon arrival, EMS immediately observed the resident had a right-sided facial droop. Facility staff reported the resident was last seen at her baseline at 7:00 a.m. when morning medications were administered. Staff reported they re-assessed the resident noting the resident's speech became more slurred as the day progressed. EMS transported the resident emergently to a hospital specializing in stroke care for further evaluation and treatment.

Review of the resident's hospital record indicated the resident was diagnosed with an ischemic stroke deep in the left side of the brain that controlled thinking, feeling, and movement on the right side of the body. The resident spent several days in the hospital then discharged to an inpatient rehabilitation facility where she spent several weeks.

The resident was discharged back to the facility. The resident never returned to her baseline status and was admitted to the facility's memory care unit.

When interviewed, an unlicensed staff member stated the resident's family member called them asking them to check on the resident because the family member thought the resident acted weird, could not get her words out, and the resident's self-report of not feeling well. The staff member stated between 9:30 a.m. and 10:00 a.m., she and another unlicensed staff member checked on the resident while she was attending church services in the facility. The unlicensed staff member stated they obtained the resident's vital signs and stated the resident talked "fine" and said she felt better. The staff member stated the resident's family members were updated on the resident's condition.

When interviewed, another unlicensed staff member stated on-call triage [the AP] called the facility stating the family called earlier in the day, wanting someone to check on the resident. The unlicensed staff member stated sometime between 1:45 p.m. and 2:00 p.m. they assessed the resident over the phone with the triage nurse, stating the triage nurse attempted to ask the resident questions but the resident had a difficult time hearing the questions. The unlicensed staff member stated after the phone assessment the resident was deemed to be okay. The unlicensed staff member agreed family members often recognize changes in a resident's condition.

When interviewed, the AP stated at 1:50 p.m. she received a call from the provider's nurse stating the resident's family member was concerned about the resident's increased confusion which was abnormal for the resident. The AP stated at 1:59 p.m. she called the facility and verbally instructed the unlicensed staff member over the phone with stroke questions to ask the resident. The AP stated the resident denied one-sided weakness or numbness and noted the resident was confused but stated the unlicensed staff member stated that was not unusual for the resident. The AP stated she could hear the resident talking and noted the resident's speech seemed clear.

When interviewed, the resident's family member stated at 9:00 a.m. she called the facility multiple times that morning due to concerns about the resident. The family member stated she talked to an unlicensed staff member who stated the resident seemed fine and was not slurring her speech. The family member stated two hours later other family members talked to the resident and were alarmed at how slurred the resident's speech was stating the resident's speech was extremely bad. The family member stated, "I could imitate what it was but it was the worst drunk you ever heard." The family member stated the resident cried stating her mouth would not work correctly.

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. Unable to interview due to current cognitive level.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility called 911 at the family's request.

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
Sherburne County Attorney
Zimmerman City Attorney
Sherburne County Sheriff's Office
Minnesota Boarding of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38981	A. BUILDING: _____ B. WING _____	C 06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREMONT VILLAGE SENIOR LIVING	26369 2ND STREET EAST ZIMMERMAN, MN 55398

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. INITIAL COMMENTS: HL389814960C/HL389811000M HL389811757C/HL389813063M On June 8, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 69 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL389814960C/HL389811000M, tag identification 2360. The following correction orders are issued for HL389811757C/HL389813063M, tag identification 630, 2360.	0 000	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. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. 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.	
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure individual abuse prevention plans (IAPP) with specific interventions to address their new vulnerability of being financially exploited for three of three residents (R1, R2, R3) reviewed after an unlicensed personnel (ULP) stole money. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included Parkinson's disease and sensorineural hearing loss. R1's service plan dated November 6, 2025, indicated R1 required	0 630		

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0 630	Continued From page 2 daily assistance with dressing and weekly linen change every Sunday. R1 used a four-wheeled walker for mobility. R1's IAPP dated September 16, 2024, indicated R1 was able to manage his finances independently, able to report financial exploitation, and was susceptible to being abused by others. R1's Adverse Event Investigation dated December 4, 2025, at 12:03 p.m., and completed by licensed assisted living director (LALD)-E, indicated R1 reported $2,750.00 missing cash, stating on November 28, 2025, he went to the bank and withdrew $2,250.00 cash and placed the money inside a closet in a locked file cabinet located in his second bedroom in the same closet where R1's bed sheets were kept. R1 stated on December 1, 2025, he observed the $2,250.00 was missing along with an envelope containing $500.00 cash. R1's Adverse Event Investigation report dated April 16, 2026, at 12:30 p.m., on April 15, 2026, a sheriff county detective placed $1,000 and a camera inside R1's apartment. Camera footage revealed ULP-F stealing several hundred dollars from the $1,000 the detective placed in R1's apartment. ULP-F admitted to stealing the money. ULP-F was asked to immediately leave the premises. On April 17, 2026, ULP-F was terminated. R1's IAPP dated May 12, 2026, lacked documentation it was updated to include R1's new identified vulnerability to being financially exploited along with specific interventions to mitigate R1's risk of further financial exploitation.	0 630		

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0 630	Continued From page 3 R2 R2's diagnoses included depression and anxiety. R2's service plan dated June 6, 2024, indicated R2 required stand-by assistance with showers every Tuesday and Saturday, and linen changes every Monday. R2 was able to report financial exploitation. R2 used a four-wheeled walker for mobility. R2's IAPP dated February 22, 2024, indicated although R2 was unable to manage her own finances and was susceptible to being abused by others. R2's police report dated April 9, 2026, at 1:57 p.m., indicated family member (FM)-D and R2 reported $330.00 cash was stolen from R2 since the fall of October 2025. R2 stated she believed the money was stolen by a staff member while she took a shower since staff stepped outside the bathroom and closed the door while R2 showered. R2's Adverse Event Investigation dated April 19, 2026, at 8:28 a.m., indicated between April 6, 2026, and April 8, 2026, R2 reported $65.00 cash stolen from her purse. LALD-E encouraged R2 to keep R2's money in a locked cabinet in her apartment. R2's IAPP dated April 8, 2026, failed to indicate a history of reported stolen money. R2's IAPP lacked documentation it was updated to include R2's new identified vulnerability to being financially exploited along with specific interventions to mitigate R2's risk of further financial exploitation. R3 R3's diagnoses included degenerative joint	0 630		

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0 630	Continued From page 4 disease, osteoarthritis of the knee, and right hip fracture. R3's service plan dated September 30, 2025, indicated R3 received assistance with linen and laundry every Friday and daily medication administration. R3 used a four-wheeled walker for mobility. R3's IAPP dated March 1, 2025, indicated R3 was unable to manage his finances and required family assistance. R3 was able to report financial exploitation. R3's Family Grievance Form dated October 29, 2025, indicated FM-C reported someone went into R1's apartment and took $200.00 out of R3's locked money box inside a locked cabinet. Keys to the to the locked cabinet and box were hidden out of sight. R3's Adverse Event Investigation report dated October 30, 2025, at 2:45 p.m., R3 reported between October 24, 2025, and October 29, 2025, approximately $200.00 missing from his money box kept inside a kitchen drawer. Audio camera placed at the top of R1's refrigerator was not pointed towards the kitchen drawer where the locked money box was kept. R1's family removed all cash from R1's apartment. LALD-E encouraged R1 and FM-C to file a police report with the county sheriff's office. R3's IAPP dated June 10, 2026, failed to indicate a history of reported stolen money. R3's IAPP lacked documentation it was updated to include R3's new identified vulnerability to being financially exploited along with specific interventions to mitigate R3's risk of further financial exploitation. During an interview on June 8, 2026, at 1:00	0 630		

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0 630	Continued From page 5 p.m., registered nurse (RN)-A stated she performed change in condition assessments. The licensee policy titled Vulnerable Adult/Maltreatment-Communication, Prevention, and Reporting, dated October 2022, indicated residents would be continually assessed, care planned, and monitored in order to identify needs and behaviors which might lead to conflict or neglect. The facility would evaluate the individual's susceptibility of abuse and also evaluate the individual's risk of abusing other adults. The plan would also include the measures to be taken to protect that individual from abuse and to minimize the risk of abuse to other vulnerable adults. TIME PERIOD TO CORRECT: Seven (7) days.	0 630		
02360	144G.91 Subd. 8 Freedom from maltreatment 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. This MN Requirement is not met as evidenced by: The facility failed to ensure three of three residents (R1, R2, R4) reviewed were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and individual persons were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public	02360		

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02360	Continued From page 6 maltreatment report for details.	02360		