Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL390346262M **Date Concluded:** November 21, 2025
Compliance #: HL390344940C

Name, Address, and County of Licensee Investigated:
Norbella Senior Living
8700 Emery Parkway North
Champlin, MN 55316
Hennepin County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Inconclusive

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):
Allegation #1: Alleged perpetrator (AP) #1 abused the resident when she yelled at him while providing cares.

Allegation #2: AP #2 neglected the resident when she ignored his request for help and his complaints of pain following a fall. Later, the resident was transported to the hospital for evaluation, where he was diagnosed with a right hip fracture.

Investigative Findings and Conclusion
Allegation #1: The Minnesota Department of Health determined abuse was inconclusive. Although video footage captured AP #1 speaking loudly to the resident, telling him to stop picking at what appeared to be a small wound on his right elbow from a fall, he can be heard telling her not to do something; however, the audio ends mid-sentence and the remainder of the exchange occurred off camera.

Allegation #2: The Minnesota Department of Health determined neglect was inconclusive During cares, the resident complained of leg pain and requested help, and it appeared AP #2 did not address his concerns nor took steps to address his pain. However, AP #2 did approach AP #1 regarding the reports of pain and AP #1 did check back with the resident before the end of the shift.

The investigator conducted interviews with administrative staff, and a family member. The investigation included review of the resident's records, incident reports, staffing schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia. The resident's service plan included assistance with all activities of daily living. The resident's assessment indicated he used two wheel walker and needed stand by assisted with transfer and mobility.

Around 5:49 p.m., the resident was found lying on his back at the nurse station.

The incident report indicated the resident told caregivers he had been trying to clean his nose and tripped. The same document indicated vital signs were taken, which were within normal limits, and the on-call nurse notified. The resident had a quarter-sized scratch on his right elbow and nurse directed the area to be cleaned and covered with a bandage. The report indicated the resident could move his arms and legs as usual and his cognition was at baseline. The nurse instructed AP #1 to check on the resident every two hours for signs of pain, injury, and difficulty with walking or transferring. AP #1 verbalized understanding. The report was signed at 6:39 p.m. on the same day.

The resident's service plan was updated the same day, with every-two-hour safety checks scheduled at 6:30 p.m., 8:30 p.m., 10:30 p.m., 12:30 a.m., and so on.

Several short video clips were reviewed for the events which occurred in the resident's room after the fall.

AP #1

At 6:03 p.m., video footage showed AP #1 pushing the resident in his wheelchair into the room and turn into the bathroom, which was out of view. As AP #1 turned the resident into the bathroom, his right side came into view and a wound on his right elbow became visible. Once the two were in the bathroom and out of view, AP #1 could be heard asking the resident to stand up.

At 6:09 p.m., video footage showed AP #1 walking out of the bathroom to retrieve the resident's wheelchair. As AP #1 re-entered the bathroom, the audio recorded her speaking loudly say stop picking at "it". While out of view, AP #1 and the resident begin talking over each other with AP #1 repeating to stop picking/touching it and the resident saying "Hey…. Don't

sla…" with the video and audio cutting off at that moment. At the time of this verbal exchange, neither the resident nor AP #1 are within view.

The resident's medication sheet indicated AP #1 administered two 500-mg tablets of acetaminophen at 8:00 p.m. for pain.

During the interview, AP#1 stated the resident had fallen and she called the nurse. AP#1 took his vital signs, and the resident complained of pain in his arm. She said she took him to the bathroom, cleaned the wound, and applied a bandage. She stated she did not slap him to stop him from picking at his wound but did direct him away from it.

During the investigation, the resident could not be interviewed due to cognitive loss.

The Minnesota Department of Health determined abuse was inconclusive regarding AP #1.

AP #2

At 8:58 p.m., later that same evening, the video showed AP #2 pushing the resident in the room in his wheelchair. The resident said, "My leg," while she pushed him to the side of the bed. She removed the blanket from his bed and asked him to stand up. The resident stated his leg hurt so badly that he could not stand. He attempted several times on his own but was unable to stand, so she assisted by grabbing his pants from behind. AP #2 pulled his pant from the back and pivoted him onto his bed. AP #2 asked him to lift his legs, and he was able to lift them himself. After lying down, he asked, "What do I do now?" She told him to scoot up in the bed, and he asked her for help. Instead of assisting him, she stood at the side of the bed and watched him. The resident said his leg hurt and she needed to help him. AP #2 told him she would give him some pills tomorrow. He said he needed help, did not know what to do and repeatedly stated his leg hurt. AP #2 repeatedly responded, "You are okay. You are fine," while he continued saying, "This leg hurts so bad, please come back."

At 9:03 p.m., the video footage showed the resident continuing to ask for help while AP #2 remained in the room. She said, "You are in bed. Sleep." He then asked for his walker, and she told him she would go check. She turned off the light and left the room.

At 9: 13 p.m., the video showed AP#2 entering the room and retrieving the walker from the resident's bathroom, placing it beside his bed. He asked for help, and she responded, "Good night."

At 9:35 p.m., the video showed AP #1 enter the room, do something towards the resident and the said "Good night. It's time to sleep".

At 10:03 p.m., the video showed a caregiver open the door to check on the resident, who was apparently asleep.

AT 12:05 a.m., the video showed a caregiver enter the room, who found the resident on the floor next to his bed.

During an interview, AP#2 stated she was working as a float caregiver that day. She said she was sitting in the common area when the resident fell the first time, and she assisted the caregiver in helping him up. AP #2 stated she was not trained to administer medication, and that AP#1 was responsible for caring for the resident that night. She also said that around 9 p.m., the resident asked her to put him to bed. She stated she could not remember whether she put him to bed by herself or with another caregiver, but she recalled that he had a regular bed and was complaining that his leg was in pain. She said she informed AP#1 about his pain but did not notify the nurse. She then walked to a different station and later returned to check on the resident, at which time she saw him asleep.

During the same interview cited above, AP #1 stated she was working with another client when AP#2 came to inform her the resident was in pain. She said she told her that she was busy and would check on him when she was finished. When she went to his room, the resident was already asleep, so she did not administer any pain medication that night. She stated the only pain the resident had was the pain in his arm, which she had already addressed. She said she was terminated because of this incident.

During an interview, a family member stated the nurse called to notify her about the first fall. The family member stated the nurse told her the resident had cut his arm, and the facility would check on him every hour. She said she had a camera installed in the resident's room, and because she did not see him in the room after the first fall, she assumed the caregiver(s) kept him in the wheelchair in the common area until 9:00 p.m. to keep an eye on him. The family member also stated the resident used to walk around with his walker. She said the facility showed her the video of the first fall. In that video, the resident walked with his walker to the nursing station to get a tissue, lost his balance, and the caregiver responded immediately. Regarding the second fall, she stated she did not know how long he was on the floor because the camera activated only when it detected motion.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive regarding AP #2.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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 had dementia.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: AP#1 unable to reach, AP#2 interviewed.

Action taken by facility: The facility terminated the employment of AP #1 and AP #2. The facility reviewed its relevant policies and procedures.

Action taken by the Minnesota Department of Health: No further action 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
	39034	A. BUILDING: _____ B. WING _____	C 10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORBELLA OF CHAMPLIN LLC	8700 EMERY PARKWAY NORTH CHAMPLIN, MN 55316

(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 22, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL390346262M/HL390344940C. No correction orders are issued.	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.	