Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL392681880M
Compliance #: HL392687100C

Date Concluded: May 11, 2026

Name, Address, and County of Licensee Investigated:
NorBella Senior Living
2025 Michaud Way
Centerville, MN 55038
Anoka County

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

Evaluator's Name: Lori Pokela R.N.
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):
The alleged perpetrator, a facility staff member/(AP), abused the resident when the AP grabbed and pulled the resident's arms harshly to get the resident to a seated position which caused bruising on the resident's arms.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined was inconclusive. The Minnesota Department of Health determined abuse was inconclusive. Although the resident had bruises on her arms, the origin of the bruising was unable to be determined due to conflicting information provided by facility staff and the resident. The resident was also on blood thinners and had a history of bruises on her arms.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the resident's physical therapist. The investigation included review of the resident record, facility

internal investigation documentation, facility incident reports, staff files, staff schedules, law enforcement report and related facility policy and procedures. Also, the investigator observed the facility environment, medication administration, and observed care and interactions between the resident and staff.

The resident resided in an assisted living facility. The resident's diagnoses included cerebral infarction and right sided hemiplegia. The resident's service plan included daily assistance with dressing, grooming, skin care, toileting, behaviors and assist with two staff and a non-mechanical lift for all transfers. The resident's assessment indicated the resident was alert, and oriented with minor forgetfulness but able to make appropriate decisions. The resident used a non-mechanical lift with staff assistance due paralysis of her right arm and leg. The resident's assessment indicated the resident was independent with bed mobility by using her grab bars. Staff reviewed the risk versus benefits with the resident regarding the use of bedrails that could cause skin injury such as; bruising, cuts or scrapes. The resident's medical records indicated the resident was prescribed a daily aspirin (a medication prescribed to thin the blood and prevent clotting).

Facility documentation indicated two unlicensed staff got the resident dressed and observed a bruise on the resident's left arm. The resident informed both staff the bruise was from the night before. The administrative nurse was sent photographs of the resident's bruises.

The administrative nurse initiated an internal investigation and interviewed the resident and the AP. The AP reported that as they attempted to assist the resident to the toilet, they touched the resident's wrist, and the resident yelled out in pain. The AP apologized and asked the resident if she could proceed with assisting the resident to the toilet. The AP informed that the resident's non-mechanical lift was used to transfer the resident to the toilet, and the AP noticed a bruise on the resident's wrist but they did not intend to hurt the resident. The resident reported that a night shift staff member, grabbed and pulled her arms harshly. The resident reported that she did not think the night shift staff member knew what she was doing and did not feel safe with the staff member working at the facility. The resident requested that facility staff were properly trained on resident transfers.

Following the incident, the facility provided all nursing staff re-education that included staff to follow the resident's service plan, transfers, and to notify the nurse of any resident injury.

The resident declined to be interviewed by the investigator and the resident's family did not respond to requests for interview.

During an interview, the AP stated when the resident requested to go to the bathroom, the AP observed the resident could not get up, so they asked the resident if she needed help. The AP stated when she tried to help the resident by holding the resident's arm, the resident yelled out in pain, so the AP let go and the resident was able to get up on her own. The AP then used the resident's non-mechanical lift to take the resident to the toilet when the resident showed the

AP a peanut-sized, blue-ish, bruise on their forearm and told the AP that she caused the bruise and she apologized. The AP stated she did not observe any other bruising during the transfer and stated she reported the resident's bruise and pain to the oncoming day shift staff. The AP stated she had no intent to harm the resident.

During an interview, unlicensed staff stated they observed a large golf-ball sized bruise on the resident's left forearm and smaller bruises on the resident's right arm. The resident informed unlicensed staff of the bruise on her left forearm and showed the unlicensed staff how a night shift staff grabbed her. The unlicensed staff stated the resident informed them she did not know where the smaller bruises came from. The unlicensed staff stated the resident had a history of dry, thin skin on her arms and often had small bruises.

During an interview, the resident's physical therapist (PT) stated around the time of the incident she observed bruises on the resident's arms. The PT stated the resident informed her a staff member had grabbed her so the PT reported it to the resident's family. The PT informed the resident had a history of smaller bruises and the resident reported they were caused by staff grabbing her.

During an interview, the administrative nurse stated unlicensed staff reported the bruises and the next morning she interviewed the resident. The resident informed her that a night shift staff was harsh with her. The facility nurse stated she did not have the resident demonstrate what the night shift staff had done and stated the resident did not know the name of the night shift staff that was harsh with her. The facility administrative nurse did not interview other night or evening shift staff that may have assisted with the resident prior to the incident nor did the facility administrative nurse investigate if any of the bruises lined up with medical equipment such as the resident's bed rails and the non-mechanical lift. The facility administrative nurse stated the threshold between the resident's room and bathroom had a bump the resident's non-mechanical lift had to go over. The facility administrative nurse stated she did not feel the AP purposely meant to hurt the resident.

During an interview, facility administrative staff stated other night shift staff that were working the night of the incident were not interviewed as the AP was the only one assigned to the resident. The facility administrative staff stated she interviewed the AP, who informed her that she attempted to sit the resident up but was not able to get the resident fully off of the bed. The facility administrative staff stated the resident's family did not feel the AP intended to hurt the resident.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No, resident declined to interview.
Family/Responsible Party interviewed: No, the resident's family did not respond to emails or phone calls sent.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
Facility staff reported the incident, completed a facility investigation and retrained facility staff. The AP is no longer employed at the facility.

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
	39268	A. BUILDING: _____ B. WING _____	C 03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORBELLA CENTERVILLE	2025 MICHAUD WAY CENTERVILLE, MN 55038

(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 March 4, 2026, the Minnesota Department of Health initiated an investigation of complaint#HL392687100C/#HL392681880M . No correction orders are issued.	0 000		