Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL392683710M
Compliance #: HL392683581C

Date Concluded: November 3, 2026

Name, Address, and County of Licensee Investigated:
Norbella of Centerville
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: 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 staff did not follow the resident's plan of care regarding oral care and the resident developed oral swelling and symptoms of infection.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the swelling was not noted right away, the facility staff completed oral care and there was no evidence staff neglected the resident. In addition, when it was discovered that the resident's denture was stuck, the denture was removed, the resident's oral cavity was assessed, and recommendations were made by the resident's hospice nurse and placed on the resident's plan of care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record(s), facility incident reports, personnel files, staff schedules, and related facility policy and

procedures. Also, the investigator observed medication, treatment administrations, cares provided and staff interaction with the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with activities of daily living including oral care to the resident's own teeth. The resident's assessment indicated the resident received hospice services, and was disoriented to person, place and time.

The resident's medical records indicated the resident was admitted to the facility's memory care unit after residing in the facility's assisted living unit. The resident was independent with activities of daily living such as dressing, transfers, ambulation and grooming, including completing oral care at the time of the transfer. Two months after the resident admitted to the facility's memory care, the resident had a health decline that included multiple falls and the need for staff assistance with activities of daily living, including oral care to the resident's own teeth. The resident started receiving hospice services during that time. Approximately 4 months after moving into the memory care, the resident's family member noticed the resident received services for oral care but the service did not include staff brushing the resident's upper, partial denture. The family communicated the concern to the facility nurse, who updated the resident's plan of care to include care for brushing the resident's denture in morning and before bedtime. The resident's medical records indicated this service was completed by facility staff. Approximately one month later the resident could not remove her denture and after the denture was removed the resident's hospice nurse was unable to place the denture back into the resident's mouth due to pain. The hospice nurse made recommendations to keep the resident's dentures out for a period of thirty days, place the resident on a mechanical soft diet and the recommendation was then placed on the resident's plan of care. The resident's medical records indicated staff completed oral care without the dentures following the recommendations and the resident did not have a significant weight loss.

Dental records indicated the resident had poor oral hygiene, was at high risk for dental decay and was not wearing an upper, partial denture because it did not fit. The dental report indicated the dental recommendation of treatment to the resident's crowns and to determine if the resident needed fillings or extractions on the next dental visit.

During an interview unlicensed personnel stated she completed oral care on the resident every morning and recalled being told not to put the resident's denture back in her mouth as she would have a visit with the dentist.

During an interview a facility administrative nurse stated the resident received oral care assistance twice a day. A family member reported the resident's denture concern. The facility administrative nurse stated the resident's hospice nurse was able to remove the denture and everything looked okay. The facility administrative nurse stated she was not previously aware the resident has a partial denture. After the facility was alerted to the concern the service plan was updated.

During an interview the resident's family stated recalled speaking with a facility administrative nurse approximately five months prior to the resident's move to the facility's memory care unit when the family member asked if the resident should be seen by the dentist. The family member stated the facility administrative nurse informed the family member that would be a good idea as cavities were observed in the resident's mouth. The resident's family member stated she then made an appointment but could not get the resident into the dentist until six months later when the resident resided in the facility's memory care unit. The family member stated she cancelled the dental appointment due to the resident's recent fall and health decline. The resident's family member stated she received a care plan from the facility administrative nurse approximately four months after the resident transferred to the memory care unit and noticed the care plan indicated the resident had her own teeth but did not indicate care to the resident's upper, partial denture. The resident's family member stated denture care was then added to the resident's plan of care and approximately a month later the resident could not take her denture out so the family member could clean them. The family member stated the dentures were ill-fitting and even the hospice nurse could not get the dentures back in the resident's mouth. The resident's family member stated the resident's mouth was swollen and painful at that time and a few months later so a dentist was consulted and a recommendation was made not to place the resident's dentures back in her mouth for thirty days and to place the resident on a mechanical soft diet.

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, per family request and resident cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

Upon discovery of the resident's upper, partial denture, the resident's denture was removed by the resident's hospice nurse, assessed by both the hospice nurse and an administrative nurse and a recommendation was made to leave the resident's denture out for thirty days.
The resident's diet was updated to reflect a mechanical soft diet while the resident's partial was removed.
The resident's family was updated regarding the incident.

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 09/17/2026

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 September 17, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL392683581C/#HL392683710M. No correction orders are issued.	0 000		