Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL394251620M
Compliance #: HL394256321C

Date Concluded: May 11, 2026

Name, Address, and County of Licensee Investigated:
Hayden Grove of St. Anthony
2601 Stinson Parkway Northeast
St. Anthony, MN 55418
Hennepin County

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

Evaluator's Name: Brandon Martfeld, RN, BSN, 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 alleged perpetrator (AP), a facility staff member neglected the resident when the AP failed to follow the resident's plan of care, the resident fell, sustained a fractured femur and was hospitalized.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The AP did not follow the resident's plan of care, however, the plan of care tasks assigned to the AP would not have prevented the resident's fall. The resident walked independently, was hospitalized after the fall, and returned to the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the county medical examiner. The investigation included review of the resident records, hospital records, facility internal

investigation, facility incident report, personnel files, and staff schedules. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included dementia, osteoporosis, and unsteady gait. The resident's service plan included assistance with dressing, oral care, bedmaking, meal reminders, and wellness checks. The resident's assessment indicated the resident had impaired cognition, was independent with transfers, and walked with a walker.

The facility's internal investigation indicated the resident had a camera setup in her apartment. The camera footage indicated at 9:24 a.m. the AP arrived at the resident's apartment to give her medications. The AP provided medications, took the resident's blood pressure and left the apartment. At 10:57 a.m. the resident transferred from her bed to a standing position with blankets wrapped around her waist. The resident attempted to walk with one hand on her walker while holding onto blankets wrapped around her waist with the other hand. The resident lost her balance and fell backwards between a bed and dresser. The resident hit the left side of her head and fell onto her left elbow and left hip. Camera footage indicated for one hour and 43 minutes the resident scooted herself around the apartment then got herself up onto a couch. Through a camera speaker, a family member directed the resident to push her call pendant. Three minutes later the AP arrived at the resident's apartment. The resident told the AP she fell, and the AP called the on-call nurse. Emergency medical services were notified, and the resident was transported to the hospital.

Hospital records indicated the resident sustained a left hip fracture and surgery was completed. The resident was hospitalized for 12 days and discharged back to the facility.

During an interview, the AP stated she remembered giving the resident her medications and then left the resident's apartment to go help other residents. After a while, the resident's call light was on, she went to answer the call light and ask the resident if she was ready for lunch. The AP stated when she entered the resident's apartment, she noticed the resident had blood on her eyebrow and a family member informed her the resident fell. The AP stated she called another staff member for help and then called emergency medical services. The resident was transferred to the hospital.

During an interview, facility leadership stated the resident's family supplied them with camera footage from inside the resident's apartment that showed the resident fall. Although the AP did not follow the resident plan of care, the fall could not have been prevented. Facility leadership stated following the hospitalization, the resident was moved into a memory care unit in the facility due to the progression of the resident's dementia.

During an interview, a family member stated the resident walked independently in her apartment and did not blame the facility or the AP for the resident's fall.

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 was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Following the fall, the resident was transported to the hospital and education was completed with the AP regarding following the resident’s plan of care.

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
	39425	A. BUILDING: _____ B. WING _____	C 04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYDEN GROVE OF ST ANTHONY	2601 STINSON PARKWAY ST ANTHONY, MN 55418

(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 April 28, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL394251620M / #HL394256321C. No correction orders are issued.	0 000		