Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL29966834 6M
Compliance #: HL299665537C

Date Concluded: March 6, 2024
Date Revised: March 13, 2026

Name, Address, and County of Licensee Investigated:
Copperfield Hill The Lodge
4020 Lakeland Avenue North
Robbinsdale, MN 55422
Hennepin County

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

Evaluator's Name: Maerin Renee, RN
Special Investigator
Revised By: Matt Heffron, JD
Operations Manager

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):
Alleged perpetrator 1 (AP1), and AP2, physically abused the resident when they forcibly removed the resident from the dining room against her will, which led to the resident falling to the floor.

The alleged perpetrators (AP1 and AP2) neglected the resident when the resident was left lying on the floor after a fall for over ten minutes before receiving assistance to stand up.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined it was inconclusive whether abuse and neglect occurred. ~~AP1 and AP2 were responsible for the maltreatment~~. Some evidence indicated AP1 and AP2 forcibly grabbed the residents' arms and forced the resident from the facility dining room. AP1 and AP2 each took one of the resident's arms to walk her out of the dining room while the resident physically resisted their restraint of her arms. As the resident

continued to struggle, AP1 stepped on the resident's foot or tripped over the resident's foot, causing the resident to fall to her knees and then face-first onto the floor. AP1 and AP2 left the resident lay on the floor for over 17 minutes while they continued to complete tasks around the facility. There was insufficient evidence to determine if the actions of AP1 and AP2 constituted unreasonable confinement, or were treatment which was humiliating, harassing, or threatening. There was also insufficient evidence regarding why the resident was not assessed or helped up in a timely manner.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted a family member. The investigator reviewed records including the resident's chart, personnel files, facility policies and procedures, and the facility's internal investigation. Also, the investigator observed staff interactions with residents in the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, vertigo, and dizziness. The resident received services including help with activities of daily living, meals, medication management, laundry, and housekeeping. The resident's assessment indicated moderately impaired decision-making and could walk independently.

The facility's internal investigation indicated AP1 filed a report of injury stating she fell while assisting a resident and sustained an injury. The report indicated a memory care resident was causing a disturbance during dinnertime, so AP1 and AP2 tried to redirect her by taking her back to her apartment. In the process of guiding the resident, AP1 stated the resident continued to resist. A supervisor reviewed camera footage and indicated AP1 and AP2 attempted to escort the resident from the dining room by taking hold of both the residents' arms. The resident fell to her knees as they entered the hallway from the dining room. AP1 fell along with the resident. AP1 was helped up, but the resident was left lying on the floor for an excessive amount of time. The resident was eventually helped up when an additional staff member arrived at the memory care unit.

The internal investigation indicated the facility's fall policy was not followed. AP2 met with facility leadership, watched the video, and stated the resident was being behavioral, so she and AP1 decided to escort her back to her apartment. AP2 stated she did not mean to cause harm to the resident. AP1 did not meet with facility leadership but posted a letter of resignation.

Video of what occurred in the dining room was not available for the investigator to review, but review of video footage as AP1, AP2, and the resident entered the hallway from the dining room was available and revealed the following:
The recorded video of the incident was reviewed and AP1 and AP2 were observed leading the resident out of the dining room. AP1 was holding the resident's right arm, and AP2 was holding the resident's left arm. The resident appeared to be struggling and AP1 stepped on or tripped over the resident's right foot with her left foot and the resident fell to her knees, then face first to the floor. The resident lay on the floor on her abdomen. AP1 fell a short way with the resident, bracing her fall with her hands, appearing to slightly bump the side of her right knee on the floor. AP2

stood over AP1 and the resident. The resident did not move and continued to lay face down on the floor. AP1 laid on the floor until another resident walked in from the dining room and helped AP2 get AP1 off the floor. The other resident, AP1, and AP2 returned to the dining room while the resident continued to lay on the floor. The resident laid alone in the hallway face first on the floor. AP2 returned to hallway and started picking up the napkins and placemats that had fallen around the resident when she fell. AP2 walked back into the dining room without providing the resident any assistance.

The resident was observed struggling to get off the floor. The resident eventually was able to sit up and began to scoot on her bottom down the hallway. AP2 returned to hallway and appeared to talk to the resident while the resident continued to sit on the floor. AP1 walked down the hallway and AP1 and AP2 stood over the resident talking to each other while the resident remained on the floor. AP1 and AP2 then walked away toward the dining room. AP2 stepped over the resident as she walked away. Eventually, a staff member from Assisted Living (AL) entered the hallway and saw the resident on the floor. The other staff walked toward the dining room, and then returned to the resident with AP2. The AL staff and AP2 assisted the resident off the floor. The resident was on the floor for over 17 minutes.

When interviewed, a supervisor stated she reviewed video of what occurred in the dining room with the resident and AP1 and AP2. The resident needed redirection because of behaviors, however, AP1 and AP2 forcefully grabbed the resident's arm. AP1 and AP2 were trying to drag the resident out of the dining room while the resident was resisting. The supervisor indicated when the video switched to the hallway, AP1 and AP2 continued to force the resident out of the dining room when the resident fell. The supervisor stated she believed it was the nature in which AP1 and AP2 escorted the resident out of the dining room that caused the resident to fall. The video of the events in the dining room was unable to be reviewed during the investigation.

When interviewed, AP1 stated the resident caused "chaos" in the dining room and attempts at redirection were unsuccessful. She and AP2 each took one of the residents' arms to escort her back to her apartment, as the resident resisted. In the process, both the resident and AP1 fell to the floor. AP1 worked the rest of the shift passing medications, but stated she was in pain and could not assist AP2 in helping the resident off the floor.

When interviewed, AP2 stated the resident was taking other people's drinks in the dining room. She and AP1 tried to redirect her and when redirection failed, she and AP1 decided to take the resident to her apartment. AP1 and AP2 each took a hold of one of the resident's arms to take her to her apartment, and the resident fought them. AP2 stated the resident was fighting AP1 and AP2 and that's how the resident fell. AP1 said her knee hurt so she was unable to help AP2 get the resident up from the floor. AP2 stated she needed to wait for someone from another unit to help her get the resident off the floor since she could not do it alone.

In conclusion, the Minnesota Department of Health determined it was inconclusive whether abuse and neglect were substantiated.

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;
(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; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

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 due to cognition.

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

Action taken by facility:
The facility completed an internal investigation, provided re-education to staff regarding procedures after a resident fall. The APs are no longer employed at the facility.

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.

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible parties 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
Hennepin County Attorney
Robbinsdale City Attorney
Robbinsdale Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29966	A. BUILDING: _____ B. WING _____	C 01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPPERFIELD HILL THE LODGE	4020 LAKELAND AVENUE NORTH ROBBINSDALE, MN 55422

(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****** AMENDED 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: #HL299665537C/#HL299668346M On January 17, 2024, 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 94 residents receiving services under the provider's Assisted Living with Dementia Care license. On March 13, 2026, the correction order previously issued for #HL299665537C/#HL299668346M, tag identification 2360, was rescinded. As a result, no correction orders are issued for this investigation.	0 000		