Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL319621520M
Compliance #: HL319626160C

Date Concluded: July 28, 2026

Name, Address, and County of Licensee Investigated:
Meadow Ridge Senior Living
7475 Country Club Drive
Golden Valley, MN 55427
Hennepin County

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

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Substantiated, individual responsibility

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) neglected the resident when she failed to log into the call pendant system and fell asleep. The AP was unavailable to answer the resident's call pendant when she needed pain medication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP was sleeping during her scheduled shift when the resident triggered her call pendant to request pain medication. After the AP did not respond, the resident wandered the unit, calling for help. Unable to find the AP, the resident called 911 for assistance. Two other staff members, who were assigned to different floors than the AP, greeted emergency medical services (EMS) personnel when they arrived. One of the staff members then responded to a pendant call from a second resident on behalf of the AP. After about five minutes, staff found the AP and woke her up. The AP briefly talked with EMS before they took the resident to the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included muscle weakness and chronic pain syndrome. The resident's services included assistance with activities of daily living, meals, and medication management. The resident's assessment indicated she had been hospitalized for acute respiratory failure and returned to the facility on hospice services.

A facility document indicated on an overnight shift, the resident's call pendant alarmed for almost 1 ½ hours. Camera footage showed the resident left her room and walked toward a medication cart. The resident then walked to the front common area and appeared to look up the stairwell and call for help. The resident returned to the common area and called 911 for help. Camera footage showed two caregivers, assigned to work on different floors than the AP, talked to EMS when they arrived. One of the caregivers helped a second resident on the AP's assigned floor whose pendant had alarmed and went unanswered by the AP. Camera footage further showed the AP asleep on a couch in the activities room for nearly two hours. When interviewed, the AP said she "might have been sleeping," and had not logged into the call pendant system, so she would not have known when call pendants alarmed. The document concluded that the resident (who was on hospice care) had an unnecessary hospital visit due to the AP sleeping on duty and not being attentive to resident needs. The resident needed help and pain medication but did not get it. Pain medication was available for the resident but was not given. The AP also did not follow the protocol for call pendants. Another facility document indicated the AP had previously received a final warning for sleeping while on duty, with video and photographic evidence.

The resident's pendant report indicated her call pendant alarmed for over 79 minutes on the night she went to the hospital.

The resident's medication administration record (MAR) indicated the AP last administered 5 milligrams (mg) of morphine (narcotic pain medication) to the resident around midnight. The resident also had methocarbamol (muscle relaxant) available to take for pain up to three times a day as needed (PRN). The resident did not receive any methocarbamol on the overnight shift. In addition, a morphine disintegrating tablet to be taken sublingually (under the tongue) up to once an hour PRN for pain was available for the resident but was also not administered.

Hospital records indicated the resident was seen in the emergency department for "confusion" and returned to the facility with a discharge diagnosis of "hospice care patient."

When interviewed, a supervisor said staff were required to log into the call pendant system upon arrival at the facility. On this shift, the AP said she forgot to log into the call pendant system and did not answer the resident's call. When her call pendant went unanswered, the resident left her room, looked for the AP and called 911 when she was unable to find her. The resident returned from the hospital the same night. The resident's care was provided by hospice, so the hospital visit was unnecessary and inappropriate. The supervisor reviewed camera footage and saw the AP appear to be sleeping on a couch in the activity room for approximately two hours. The AP had already received a final warning for sleeping during her shift on a previous occasion. When the AP was sleeping and did not answer the resident's call pendant, the resident ended up going to the hospital instead of simply getting the pain medication she needed.

When interviewed, a family member said he thought the resident received excellent care in general. The resident only moved because she needed a higher level of care.

When interviewed, the AP said she administered the resident's scheduled pain medication around midnight. The resident called again for more pain medication, while the AP said she dozed off for a little bit. The AP said another staff member woke her up to let her know EMS was taking the resident to the hospital. The AP later explained to a supervisor that the resident already had her pain medication and the paramedics said she was ok and was just confused. The AP said she would not have been able to administer more pain medication to the resident for another 4 to 6 hours, anyway. The AP said the resident often rang her call pendant and roamed the halls, so that was not new for her. The AP said she was logged into the call pendant system but had not turned the volume up. The AP said she had two pendant calls, but she was asleep so she did not hear the other one.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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, cognitive status prevented interview.

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

Action taken by facility:
The facility completed an investigation. The AP is no longer employed by 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.

To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

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

The responsible party 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
Golden Valley City Attorney
Golden Valley Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31962	A. BUILDING: _____ B. WING _____	C 05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW RIDGE SENIOR LIVING	7475 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

(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****** 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: HL319626160C/HL319621520M On May 26, 2026, 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 101 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for HL319626160C/HL319621520M, tag identification 2360.	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		