DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL319621703M
Compliance #: HL319622710C

Date Concluded: July 15, 2025

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

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

Evaluator's Name: Nicole Myslicki, RN
Special Investigator
Rhylee Gilb, RN
Special Investigator

Finding: Substantiated, facility and 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 facility neglected the resident when the resident fell after a meal service. Staff failed to physically assist the resident who was trapped between the wall and his electric wheelchair. The resident passed away from the incident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility and alleged perpetrator (AP)2 were responsible for the maltreatment. The facility was aware of the resident's recent falls in the dining room. The facility failed to enforce nursing staff (caregivers) remain in the dining room during meals to monitor the resident and provide standby assistance. Additionally, the facility fall policy directed an erroneous order to not touch a resident after a fall and did not direct staff to aide for life-threatening situations. AP2, a caregiver unlicensed personnel (ULP), and AP1, a dietary staff member, were in the dining room at the time of the

incident. AP2 and AP1 watched idly as the resident struggled to get into his electric scooter for over several minutes and fall into a suffocating position between the wall and his scooter. AP2 failed to attempt to provide any physical assistance to the resident or to try to move his electric scooter. AP2 instructed dietary staff, including AP1 not to touch him. AP1 was not responsible for the maltreatment due to not receiving prior training on falls or transfer assistance and being instructed to not touch the residents. However, several staff including AP2 watched the resident without intervening or calling 911 after there was no longer signs of his chest rising and falling for breaths viewed on the video footage. The resident was dead when law enforcement arrived.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family and law enforcement. The investigation included review of the resident record, death record, video footage of the incident, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed the dining room, a meal service, and transfer assistance.

The resident resided in an assisted living facility. The resident's diagnoses included arthritis and vertigo. The resident's service plan included assistance with safety checks due to being a fall risk, reminders to independently go to the dining room for meals, and transfer assistance with cues and standby assistance. The service of transfer assistance instructed staff to cue and prompt the resident through the transfer, and ensure the resident had any applicable mobility equipment nearby.

The resident's assessment indicated the resident needed cueing and/or standby assistance during transfers but stood independently. The assessment indicated he had several falls within a couple of months and identified him as being a fall risk, noting he may be unable to safely walk. The intervention plan in place for staff included promptly reporting falls to the nurse and completing fall safety checks.

A facility incident report indicated a dietary staff member told AP2 the resident fell off his scooter and laid across it, with his neck being pinched between the scooter and a wall. AP2 attempted to call the lead staff for the building, but did not reach him, so AP2 called 911. AP2 then walked out of the dining room and called the lead staff member again. At that time, first responders arrived, disassembled the resident's scooter, and removed it from his neck. Responders laid the resident on the floor and performed CPR until they pronounced him deceased.

The law enforcement report indicated they arrived on scene at 5:35 p.m., after receiving a report of an unconscious resident. The resident appeared to have fallen off his electric scooter. His body wedged between the seat and steering column, with his head down on the floor between the scooter and corner of a wall. The resident's upper body weight pressed down on his bent neck and head. The resident appeared blue in the face and did not have a pulse. After

the fire department arrived, four responders lifted the resident off the scooter and onto the floor and started cardiopulmonary resuscitation (CPR) until paramedics arrived and took over. Paramedics stopped CPR attempts and pronounced the resident deceased at 6:04 p.m.

The resident's death record identified positional asphyxia (the body being in a position which prevents the person from breathing) as the cause of death.

The facility's internal investigation indicated the resident got up from the dining room chair after dinner and tried to sit on his scooter, parked behind the dining chair. The resident sat down onto the scooter but leaned to the side. He eventually fell between the wall and the scooter head down. The resident fell at 5:29 p.m. A dining room resident and AP1 notified AP2 who approached the resident at 5:30 p.m. and attempted to contact others for assistance. Staff did not move the resident. The staff member notified 911 who arrived at 5:42 p.m. The responders needed to remove the scooter's seat before several responders lifted the resident up and onto the floor. The responders attempted CPR and other medical care for about twenty minutes but were unsuccessful.

Facility video footage showed the resident got up from a dining room chair and walk to his electric scooter behind him. The scooter faced the corner of the room. In the dining room, AP1 bussed and cleaned tables. The resident held onto the steering wheel of the scooter while trying to transfer onto the scooter. At 5:25 p.m., the resident sat down on his scooter at an angle, with his upper half leaning towards the wall and legs stretched out toward the center of the room. AP1 appeared to look over at the resident before going back to his job duties. The resident continued to lean further, as he struggled to get himself sitting upright with a rocking motion. AP1 walked towards the view off camera, appeared to speak to someone (no audio) with a hand gestured towards the resident. After about three minutes of slowly falling into a side lying position across the seat of his scooter, the resident appeared to twist and fall headfirst, laying face down across the seat of the scooter, still holding onto the steering wheel with his right hand. Toward the other side of the dining room, another resident pointed in the resident's direction and appeared to have informed someone. At 5:29 p.m., the resident fell completely off the seat of his scooter, becoming wedged head-down. His head was pinned between the wall and the base of his electric scooter with his hips in between the steering column and seat, where feet would normally rest during operation. The resident's right hand released from the steering wheel. He continued to move his legs intermittently. Less than a minute later, AP2 walked toward the resident but did not try to assist or touch him, and did not appear to talk to him. AP2 walked out of view briefly but then returned, eighter seconds later appearing to speak to AP1, dietary staff (DS)-1, and DS-2 with argumentative facial expressions, gesturing her arms towards the resident. The resident's right arm continued to move intermittently and his back moving with his chest rising and falling with breaths. Two minutes after the resident's head became stuck, AP2 began using a cell phone while speaking to AP1, DS-1, and DS-2, as they walked out of view. AP2 faced away from the resident. The resident's back appeared to rise and fall for the two minutes in that position until rising and falling was no longer visible. AP2, still with her back to the resident, walked out of view, making a phone call.

The resident remained alone for about two minutes, until DS-1 and DS-2 returned into view. ULP-1, and ULP-2 followed behind and walked over to the resident. ULP-1 tapped the resident on the back several times, and ULP-2 made a phone call. Less than one minute later, AP2 walked back into view and began speaking to the two ULPs, AP1, and DS-2. One minute later, AP2 made another call while the two ULPs stood over the resident and scooter. About ten minutes after the resident became stuck, ULP-1 and ULP-2 briefly attempted to move the resident until AP2 walked back into view and spoke to them. At 4:41 p.m. law enforcement walked into view and approached the resident. The law enforcement officer attempted to move the resident but was unable. The officer pushed the scooter backwards away from the corner and wall, and ULP-1 again briefly attempted to help move the resident. Less than one minute later, fire fighters walked into view. Law enforcement and fire fighters removed the scooter's seat, and four responders lifted the resident off the scooter and onto the ground. Law enforcement began CPR until ambulatory service responders arrived and took over. Responders performed CPR for about twenty minutes.

During an interview, DS-1 stated AP1 came into the kitchen, informing her and DS-2 the resident fell, and his head became stuck. AP2 had been in the dining room, so they called her over to come and help, but AP2 stated it was not her job after seeing the resident. DS-1, DS-2, and AP2 left the dining room, and each went to different units to look for another ULP. DS-1 did not find another ULP, so she went back to the dining room. AP2 kept telling the dietary staff it was not her job, and DS-2 and AP2 began to argue. One of the dietary staff asked AP2 to call 911. After DS-1 returned from searching one of the units, the resident had already urinated on himself. Years prior, the facility had a staff person monitor the residents in the dining room, but that practice ended. DS-1 stated the resident had fallen on another day in the dining room. Dietary staff were not allowed to touch residents, but a ULP had been in the dining room during that fall.

During an interview, DS-2 stated the facility had instructed dietary staff only to contact a ULP if a resident fell or in case of emergency. The resident fell often, including two days before the incident. Previously, when the resident fell in the dining room, dietary staff went and got ULPs to come help. But during this incident, no one helped. AP1 ran into the kitchen, informing DS-2 and DS-1 the resident fell. In the dining room, DS-2 observed the resident with his head bent down, waving his arm and gasping for air. AP2 told them they could not touch him. DS-2 told AP2 to help the resident, but AP2 declined, stating she could not, due to the resident's size. DS-2 told AP2 she still needed to help him. DS-2 ran to a memory care unit for help, but the ULP said he could not come help because AP2 did not return to the unit.

During an interview, nurse-1 stated ULPs were instructed to not touch a fallen resident. Moving someone could cause more injury. Prior to this incident, kitchen staff were instructed to notify nursing if a resident fell. After the incident, the facility installed a call pendant in the dining room for the kitchen staff to push for assistance. Nurse-1 stated the resident received cueing and standby assistance for transfers, but he needed to push his pendant for help which he did not often do. A staff member needed to be present to make sure he had a safe transfer.

During an interview, the licensed assisted living director (LALD) stated the resident had a couple of falls in the dining room prior to this incident. The ULPs should be attentive and monitoring the dining room, but he did not require a specific staff member to be in the dining room at all times. The LALD stated he and the director of nursing completed the internal investigation. He interviewed staff and residents. The LALD stated a staff member did respond to the incident, but staff did not move the resident. He had to do a lot of education and training with staff including how to respond, as well as implementing the call pendant in the dining room.

During an interview, AP2 stated she had been scheduled on a memory care unit the shift the incident occurred. AP2 left the memory care unit to get a cup of coffee. While in the assisted living dining room getting coffee, residents at a nearby table started having a conversation with her. AP2 stated her back faced the resident when she heard kitchen staff yelling for help. AP2 walked over and found the resident lying partly on the scooter with his head down and neck squeezed against the wall. AP2 called the resident's name, but he did not respond. One of the dietary staff thought the scooter may have been able to be moved, but AP2 refused for the scooter to be moved. AP2 stated dietary staff asked her if she could move the scooter, but she was skeptical to try, worried moving the scooter could hurt his head. AP2 stated she did not know his scooter because all scooters were different, and she did not want to do more harm than good. After calling for another ULP, AP2 stated she decided to walk away from the scene and call 911.

During an interview, a family member stated the resident had trouble walking due to knee and hip replacements, his size, and vertigo. The resident had several falls in his apartment and the dining room prior to the incident. During all that time, the facility never changed his plan of care, and he received no hands-on help with transfers.

The facility's fall policy and procedure directed staff to not touch a resident after a fall, but to call the nurse, observe for injury and take vital signs. If the nurse was not onsite and the resident was hurt, the policy directed staff to call 911, then notify the nurse.

Minnesota Statute 604A.01, subdivision 1, Good Samaritan Law, duty to assist, indicates a person at the scene of an emergency who knows that another person is exposed to or has suffered grave physical harm shall give reasonable assistance to the exposed person.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The facility and AP2 followed an erroneous order, direction or care plan with awareness and failure to take action.

The facility and AP2 directed an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

AP2 followed the facility directive and/or policies and procedures.

(3) The facility and AP2 failed to follow professional standards and/or exercise professional judgement.

The facility and AP2 failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No. The resident is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: AP1: No, did not respond to attempts to contact. AP2: Yes.

Action taken by facility:
The facility completed education with staff after the incident. The facility also put a call pendant in the dining room to alert nursing staff of emergencies.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. 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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
Hennepin County Sheriff's Office

Minnesota Department of Health

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 06/04/2025

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****** 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: HL319622710C/HL319621703M On June 4, 2025, 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 99 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL319622710C/HL319621703M, tag identification 2310, 2360. On August 8, 2025, the orders were amended to correct the level of the 2310 order.	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.	
02310 SS=L	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1	02310		

(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to provide services according to accepted health care standards when they failed to promptly attempt to move one of one residents (R1) when he suffered entrapment after he fell, and his neck became wedged between his electric scooter and the dining room wall. R1 died from positional asphyxiation. The licensee's deficient practice had the potential to affect all residents.

This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

R1's diagnoses included vertigo, obesity, and arthritis. R1's service plan dated March 31, 2025, indicated R1 received cueing/standby transfer assistance. The service became effective December 12, 2024, and directed staff to cue and prompt R1 through the transfer, ensuring they had mobility equipment nearby before the transfer as applicable. The service plan also indicated R1 received assistance with safety checks three times daily due to being a fall risk. The service became effective October 25, 2024.

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02310	Continued From page 2	02310		

R1's assessment dated March 19, 2025, indicated R1 had a history of falls and may be unable to safely ambulate. The assessment identified him being a fall risk as a vulnerability.

An incident report dated March 30, 2025, at 5:33 p.m., indicated ULP-D had been in the assisted living dining room, getting coffee and spoke with residents. Dietary staff (DS)-E informed ULP-D R1 fell off his scooter and was lying across his scooter with his neck being pinched between his scooter and the wall. ULP-D called 911 and reported the situation while R1 had been losing consciousness. ULP-D walked out of the dining room to make a call. While making the call, first responders arrived, disassembled the scooter, freed his neck, then laid him on the floor and performed cardiopulmonary resuscitation (CPR) until calling his time of death. The report did not indicate vital signs were taken by licensee staff during the incident.

Video footage provided by the licensee showed R1 got up from a dining room chair and walk to his electric scooter behind him. The scooter faced the corner of the room. In the dining room, DS-E bussed and cleaned tables. The resident held onto the steering wheel of the scooter while trying to transfer onto the scooter. The resident sat down on his scooter at an angle, with his upper half leaning towards the wall and legs stretched out toward the center of the room. DS-E appeared to look over at the resident before going back to his job duties. The resident continued to lean further, though he appeared to be attempting to get himself sat back up with a rocking motion. After about three minutes, the resident appeared to twist and fall headfirst, still holding onto the steering wheel with his right hand. The resident's buttocks faced the ceiling,

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02310	Continued From page 3 with his feet hanging over the right side of the scooter. Toward the other side of the dining room, another resident pointed in R1's direction and appeared to have informed someone, as R1 continued twisting and falling headfirst until becoming wedged head-down with his hips in between the steering column and seat, where feet would normally rest during operation. R1's right hand released from the steering wheel. He continued to move his legs intermittently. Less than a minute later, ULP-D walked toward the resident but did not try to assist or touch him, and did not appear to talk to him. ULP-D walked out of view briefly but then returned, appearing to speak to DS-E, DS-G, and DS-H. R1's right arm continued to move intermittently. About a minute and a half after R1 became stuck, ULP-D began using a cell phone while speaking to DS-E, DS-G, and DS-H, as they walked out of view. ULP-D faced away from the resident. R1's back appeared to rise and fall for nearly two minutes in that position until rising and falling was no longer visible. ULP-D, still with her back to R1, walked out of view, making a phone call. R1 remained alone for about two minutes, until DS-G and DS-H returned into view. ULP-F, and ULP-J followed behind and walked over to the resident. ULP-F tapped the resident on the back several times, and ULP-J made a phone call. Less than one minute later, ULP-D walked back into view and began speaking to the two ULPs, DS-E, and DS-2. One minute later, ULP-D made another call while ULP-F and ULP-J stood over R1 and the scooter. About ten minutes after R1 became stuck, ULP-F and ULP-J briefly attempted to move R1 until ULP-D walked back into view and spoke to them. Less than two minutes later, law enforcement walked into view and approached R1. The officer attempted to move R1 but was unable. The officer pushed the scooter	02310		

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02310	Continued From page 4 backwards away from the corner and wall, and ULP-F again briefly attempted to help move R1. Less than one minute later, fire fighters walked into view. Law enforcement and fire fighters removed the scooter's seat, and four responders lifted R1 off the scooter and onto the ground. Law enforcement began CPR until ambulatory services responders arrived and took over. Responders performed CPR for about twenty minutes. R1's death record identified R1's cause of death as positional asphyxia. During an interview June 11, 2025, at 11:03 a.m., registered nurse (RN)-A stated ULPs were instructed to not touch a fallen resident. Moving someone could cause more injury. During an interview June 13, 2025, at 10:04 a.m., DS-H stated ULP-D told him and other DS they could not touch R1 after he fell, and his neck became wedged. DS-H told ULP-D to help R1, but ULP-D stated she could not either. During an interview June 17, 2025, at 10:32 a.m., licensed assisted living director (LALD)-B stated a staff member did respond to the incident, but staff did not move R1. LALD-B had to do a lot of education and training with staff including how to respond. The licensee's policy Fall Incident and Procedure, dated November 20, 2024, directed staff to not move a resident after a fall, but to call the nurse, observe for injury and take vital signs. If the nurse was not onsite and the resident was hurt, the policy directed staff to call 911, then notify the nurse. The licensee failed to update the policy after the incident.	02310		

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02310	Continued From page 5 TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, 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(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and an individual person were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		