Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL360925502M
Compliance #: HL360922772C

Date Concluded: December 15, 2025

Name, Address, and County of Licensee Investigated:
Artis Senior Living Facility
8155 Afton Rd
Woodbury, MN 55125
Washington county

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

Evaluator's Name: Deb Schillinger RN BSN
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 the resident was calling for help and the AP did not respond.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP, an unlicensed caregiver, opened the resident's door to complete a safety check, however the closed the door while the resident called for help.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed resident and facility staff interactions during an onsite visit.

The resident resided in an assisted living memory care unit. The resident's diagnoses included vascular dementia. The resident's service plan included hourly safety checks and assistance of two caregivers for mobility, transfers and toileting. The resident's assessment indicated the resident required hourly safety checks and was a high risk for falls. The resident had returned to the facility two days before the incident, after she had received rehabilitation after a previous fall with injury.

A concern arose when video footage with audit showed the AP failed to assist the resident, who was calling for help when the AP opened the door to complete the safety check. The resident's calling for assistance became louder after the AP closed the door. Later the resident was found on the floor by unlicensed caregiver #1.

An internal investigation indicated the resident was found on the floor after an unwitnessed fall by another caregiver. Later, the facility viewed footage from a camera within the resident's room which showed the AP assigned to provide care for the resident did not fully complete a "safety check" but merely opened the door, looked in and quickly closed the door. The same footage included audio of a voice calling for help from within the apartment which grew louder as the AP closed the door. Another unlicensed caregiver, who was passing medications, heard the resident's calls for help approximately 20 minutes later and initiated the help the resident needed. The resident later transferred to the hospital.

The video footage provided by the family member indicated at 5:10 a.m. the resident was seen walking from the bed into the bathroom. The next video was timestamped at 5:58 a.m. where the AP opened the door, and the resident could be heard calling out "help me". The AP then leaned in and stated "checking on you", the resident could be heard calling out again "help me", then the AP closed the door. After the door closed, the resident called out louder for help.

During an interview, the AP stated he was assigned to provide care for the resident. The AP stated he was the only caregiver assigned for the area where the resident resided, which was a very busy unit where the majority of the residents need total assistance. The AP stated when unlicensed caregiver #1 notified him the resident was on the floor, he stated he had just completed his last round a few minutes prior, and the resident was lying in the bed. The AP stated at that time of his last safety check around 6 a.m., the resident was in bed, and he spoke to her. The AP stated the resident was able to use her pendent and was known to call staff for assistance using her pendent.

During an interview, unlicensed caregiver #1 stated he was working the same shift as the AP, but he floated from unit-to-unit as a medication passer. Unlicensed caregiver #1 stated he and the AP discussed the resident's need for hourly safety checks as the resident was a high fall risk at the beginning of the shift. Unlicensed caregiver #1 stated he was on the unit to pass medications when he heard the resident calling out for help and found the resident on the bathroom floor. He called the AP to help, and the resident was put back in her bed after notifying the triage nurse. Unlicensed caregiver #1 stated he later saw the video from the

resident’s room and the resident was already in the bathroom calling for help when the AP did his safety check by opening and closing the door.

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.
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: no, due to cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: An internal investigation was completed, and the AP is no longer employed at the facility.

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
Washington County Attorney
Woodbury City Attorney
Woodbury Police Department
MN Department of Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36092	A. BUILDING: _____ B. WING _____	C 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LVG OF WOODBURY	**8155 AFTON ROAD WOODBURY, MN 55125**

(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: #HL360922772C/#HL360925502M On September 18, 20225, 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 55 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL360922772C/#HL360925502M, tag identification 1640 and 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.	
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 1 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written service plan was revised and signed by the resident or resident representative to reflect the current services provided for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01640	Assisted Living Provider 144G. 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	

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01640	Continued From page 2 The findings include: R1 R1 diagnoses included vascular dementia. R1 was readmitted to the facility on August 11, 2025. R1's care plan dated May 29, 2025, indicated R1 was at high risk for falls and required the assistance of two caregivers and use of a gait belt to complete tasks including transfers, ambulation and toileting. The care plan also indicated R1 required hourly safety checks, however the frequency listed on the care plan indicated the check was to be completed three time daily, one time on each of the three shifts. R1's care plan dated May 29, 2025, did not indicate an update was made upon the readmission to the facility on August 11, 2025, after a 42-day rehabilitation stay indicating new delegation related to recent left shoulder surgery. The Comprehensive assessment on August 11, 2025, failed to address recent left shoulder surgery or new needs or precautions related to new diagnosis. R1's signed service agreement was dated January 27, 2025, indicating an updated service plan was not reviewed with the resident or resident representative upon readmission. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640	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.	

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02360	Continued From page 3	02360		
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 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		