

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report : HL390343267M
Compliance : HL390342569C

Date Concluded: September 3, 2026

Name, Address, and County of Licensee

Investigated:

NorBella of Champlin
8700 Emery Parkway North
Champlin MN 55316
Hennepin County

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

Evaluator's Name: Maggie Regnier, 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 used an EZ-stand device to get the resident up, without waiting for a second staff member to assist with the transfer.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was substantiated. The AP, who was an unlicensed caregiver, was trained and self-reported two staff members are required to use the EZ-stand to get the resident up. The AP did not get a 2nd staff member, attempted to get the resident up by herself and the resident fell hitting her head sustaining a head laceration which needed to be treated at the emergency department. The incident did not meet the definition of an accident nor therapeutic error as the AP expressed understanding of the need for a two-person assist but did not seek that assistance.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The

investigation included review of the resident record(s), hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed staff interactions with other staff, residents and visitors.

The resident resided in an assisted living facility. The resident's diagnoses included pulmonary insufficiency, congestive heart failure, dysphagia (difficulty swallowing), high blood pressure and generalized muscle weakness. The resident's service plan included assistance with bathing, daily grooming, dressing, toileting and transferring. The resident's assessment indicated the resident was a two person assist with a mechanical lift.

The residents care plan states the resident was a two-person assist with transfers, using the mechanical lift.

A facility internal investigation indicated the AP attempted to get the resident up alone, using the easy stand, to take the resident to the bathroom. While attempting this, the resident fell, hitting the back of her head on the bathroom door, resulting in a laceration with bleeding. A second staff person, an unlicensed care giver, was summoned, the nurse was called, EMS was called and the resident was sent to the emergency department for laceration repair and later returned to the facility.

The schedule indicated the AP was working with a fellow unlicensed caregiver but did not ask that staff member to help with the transfer as written on the care plan.

During an interview, the unlicensed caregiver who was working with the AP at the time of the fall stated she had told the AP not to get the resident up alone. The unlicensed caregiver further stated the facility has a policy all residents using a mechanical lift are to be done with two people.

During an interview, the AP stated she knew the resident was a two-person assist with the lift, but the AP stated the other staff member(s) were busy, and she has gotten her up before with only one person and thought it would be ok. The AP further stated she felt terrible the resident was injured.

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" 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: Yes

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Yes

Action taken by facility: The facility suspended the AP, did staff re training, and hung signs on all lifts noting the requirement for 2 staff members to use.

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

Champlin City Attorney

Champlin Police Department

Hennepin County Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/11/2026
NAME OF PROVIDER OR SUPPLIER NORBELLA OF CHAMPLIN LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8700 EMERY PARKWAY NORTH CHAMPLIN, MN 55316		
(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: #HL390342569C/#HL390343267M On June 11, 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 37 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL390342569C/#HL390343267M, 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			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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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			