Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL288873726M
Compliance #: HL288873604C

Date Concluded: October 22, 2026

Name, Address, and County of Licensee Investigated:
The Landmark of Fridley
6490 Central Ave NE
Fridley, MN 55432
Anoka County

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

Evaluator's Name: Deb Schillinger RN BSN
Special Investigator

Finding: Substantiated, facility 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 said he wanted to leave the facility and later jumped off of his balcony.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to take appropriate actions when the resident stated he was going to jump off the balcony in his room two days before the incident. The facility did implement every two hours safety checks and began to speak with the family member regarding the need for the resident to be moved to a secured unit, but 45 minutes after his last safety check, the resident fell from the second story balcony in his room, was then sent to the hospital and died two days later.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record, death record, hospital records, facility internal investigation, facility incident reports, staff schedules, law enforcement report, and

related facility policy and procedures. Also, the investigator observed resident and staff interactions during an onsite visit.

The resident resided in an assisted living facility. The resident's diagnoses included Alzheimer's dementia. The resident's service plan included assistance with medication management and administration, safety checks, cueing and reminders to complete tasks. The resident's assessment indicated the resident was not a wander risk, was forgetful but was able to make his needs known.

A concern arose when the resident was found on the ground outside the facility after an unwitnessed fall from the 2nd floor balcony in the resident's room.

The resident was admitted to the facility eleven days before the fall.

Four days prior to the resident's fall from the balcony the progress notes indicated the resident made multiple attempts to leave the facility unsupervised and actually succeeded on one occasion. The same documents indicated he wished to return home and check on his wife.

Two days prior to the resident's fall a note written by an unlicensed caregiver indicated the resident was redirected from leaving the building. The same note indicated the resident wished to check on his wife and threatened to jump off the balcony in his room. The resident calmed down when he was told his wife would be coming to see him later that same day.

The medical record indicated the resident's elopements attempts became more frequent, the facility did add every 2-hour safety checks to the emergency plan. However, the facility did not complete a new assessment nor implement interventions aside from the 2-hour safety checks.

On the day, the resident was found outside on the ground after an unwitnessed fall from his balcony, emergency medical services were contacted immediately. A police report described a search of the resident's apartment and found evidence the resident's jump was a suicide attempt.

The resident was transferred to the hospital where he was admitted with multiple injuries and placed on comfort cares. The resident died two days later at the hospital.

During an interview, the nurse stated the resident moved in ten days prior to the incident and was not happy living in the facility. Four days after moving in, the resident moved his belongings to the foyer of the building in an attempt to leave. The nurse stated she was able to redirect the resident and later returned his belongings to his room. The day before the resident's fall, she arrived for her morning shift and found the resident was again at the front desk and was adamant he was going home, and she redirected the resident again. The nurse stated she found a note written by the unlicensed caregiver working the previous evening, indicating the resident threatened to jump off the 2nd story balcony in his room. The nurse

stated the unlicensed caregiver did not call the triage nurse but did leave the note where she would see upon arrival to her shift that morning. Later that morning, during a meeting with the resident's family member that same day, the nurse stated the family member inquired about memory care, however there were no beds available at that time. The nurse stated she offered every 2-hour safety checks for the resident, and the family member was agreeable to the safety checks. The family member also signed for the resident to see the in-house medical provider. The nurse stated she spoke to the resident 12 hours after the threats were made to jump off the balcony, where he did not repeat the verbal threats to her nor did she ask him if he had made the threats. The nurse stated the nurse manager was notified and was asked to update the residents service plan. The medical provider was not notified of the threats made to jump from the balcony. The nurse stated she updated the service plan with every two hour safety checks under the direction of the nurse manager and verbally educated the unlicensed caregivers on the new intervention.

During an interview, the nurse manager declined to be interviewed but stated she did not receive any calls regarding the resident that day.

During an interview, an unlicensed caregiver stated she was providing care for the resident two days before the fall. The resident had packed his belongings to leave the facility and was agitated when the caregivers working would not let him leave the facility. The unlicensed caregiver reported that the resident stated he was going to jump off the balcony in his room, but he was able to be redirected and did not notify the triage nurse because the resident was redirectable and the resident's attempts to leave the facility had become his normal. The unlicensed caregiver stated she felt she did everything right by documenting the interaction and leaving a note to notify the nurse in the morning. She stated she checked on the resident frequently for the remainder of her shift.

A facility training document provided indicated nursing staff or triage nurses should be notified immediately for any threats by residents of self-harm or harm towards others regardless of the time of day.

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, the resident is deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: The facility completed an investigation, and additional education was provided to facility staff members.

Action taken by the Minnesota Department of Health: The responsible party will be notified of their right to appeal the maltreatment finding.

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Anoka County Attorney
Fridley City Attorney
Fridley Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28887	A. BUILDING: _____ B. WING _____	C 08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDMARK OF FRIDLEY	6490 CENTRAL AVENUE NE FRIDLEY, MN 55432

(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: #HL288873604C/#HL288873726M On August 6, 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 66 residents receiving services under the provider's Comprehensive Home Care Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL288873604C/#HL288873726M, tag identification 2360.	0 000		
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	02360		

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02360	Continued From page 1 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 was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		