Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL273788982M
Compliance #: HL273787065C

Date Concluded: June 9, 2025

Name, Address, and County of Licensee Investigated:
Inver Grove Heights WP II LLC
9058 Buchanan Trail
Inver Grove Heights Mn 55077
Dakota County

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

Evaluator's Name: James P. Larson, RN
Special Investigator

Finding: Not Substantiated

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/facility unlicensed personnel neglected the resident when they failed to provide physical safety and implement fall precautions. The resident fell and required hospitalization for a left leg fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell and sustained a hip fracture, there was not a preponderance of evidence to support that the actions of the facility staff met the definition of neglect.

The investigator conducted interviews with facility staff members, including nursing staff. The investigation included review of the resident record, hospital records, facility incident reports, personnel files, employee training files, and facility policy and procedures. The investigator also toured the facility and observed staff interactions with residents.

The resident resided in an assisted living facility memory care unit. The resident's diagnoses included dementia, anxiety, and vertigo. The resident's service plan included assistance with all activities of daily living, routine safety checks, and medication administration. The resident's assessment indicated the resident had a history of unwitnessed falls with injury, as well as impaired cognition with poor decision making and required supervision.

The resident's medical records indicated she had history of unwitnessed falls. Records further indicated that the resident was independent with ambulation prior to the injury with occasional incidents of compulsive behavior. In the weeks and days leading up to the resident's fall with injury, facility staff recorded unwitnessed falls occurred twice in the resident's apartment.

On the day of the incident, the resident and the AP were standing in the common area of the facility having a conversation, when the AP turned and walked away the resident. When the AP turned back around the resident was on the floor. The facility followed emergency protocols, contacted Emergency Medical Services (EMS), and transported the resident to the hospital for evaluation and treatment. The resident sustained a fractured hip which required surgical intervention.

During an interview, the AP stated she was aware of the resident's previous and recent history of falls. She stated that the resident required stand by assistance during transfers but used assistive devices to ambulate. The care plan at the time of the incident indicated assistance of one person was required during ambulation. The AP recalled on the day of the incident the resident was standing in the common dining area and became agitated, shaking her walker. The AP stated after a short period of verbal interaction, she turned away from the resident to retrieve a piece of equipment, leaving the resident standing alone with her walker. As she walked away from the resident, she heard the resident yell from behind her and then saw the resident on the floor.

During an interview, a registered nurse (RN) stated she was aware of the resident's recent history of falls and that all staff were orientated to the resident's increased fall precautions and care plans. The nurse indicated that facility nursing staff provided continuous amendments to the resident's care plan to ensure safety, which including increased observation during transfers and ambulation, as well as increased safety checks when the resident was in her apartment. During an internal investigation conducted by the facility after the incident it was determined by the nursing staff that the AP failed to follow the residents care plan as instructed during transfer and ambulation when she left the resident unattended to retrieve a piece of equipment. Following the incident, the AP and all other staff were retrained on following resident care plans at all times.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

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, due to impaired cogntion.
Family/Responsible Party interviewed: No, attempts to contact were unsuccessful.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility staff provided immediate assistance and contacted emergency medical services. The resident was admitted to the hospital for care. The facility investigated the incident and required staff to attend additional training.

Action taken by the Minnesota Department of Health:
No further action at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27378	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVER GROVE HEIGHTS WP II LLC	9058 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077

(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 On April 17, 2025, the Minnesota Department of Health conducted a complaint investigation #HL273787065C/#HL273788982M for at the above provider. No correction orders are issued.	0 000	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 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.	