Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL315737482M
Compliance #: HL315737323C

Date Concluded: February 12, 2026

Name, Address, and County of Licensee Investigated:
Willows of Ramsey Hill
80 North Mackubin Street
St. Paul, MN 55102
Ramsey County

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

Evaluator's Name: Willette Shafer, 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 facility neglected the resident when the resident was found lying naked on her bare mattress and she had been incontinent of urine.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident was observed covered by a blanket in bed. The resident's brief was recently changed, and her sheets were removed to wash. Hospice arrived shortly after facility staff cleaned the resident and brought her sheets to launder. Hospice staff bathed and dressed the resident. The resident had no negative outcome from the brief period between undressing, getting clean clothes and bedding applied. At the time of the incident the resident was very agitated and difficult to provide care for. She would remove her brief and clothing. After this incident the facility worked with the resident's primary care provider to adjust her medications to decrease agitation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted hospice staff members and the resident's family. The investigation included review of the resident's record, facility incident reports, personnel files, and related facility policy and procedures. Also, the investigator toured the facility and observed facility staff providing care to the residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease, anxiety disorder, depression, agitation, and diabetes type II. The resident's service plan included assistance with medication management, transfer of assistance of two staff with a full body lift, incontinent care every two hours, bathing, grooming, meals, and housekeeping.

The resident's progress notes indicated several medications were decreased in the weeks prior to the incident. During the time of the incident the resident displayed more agitation and aggression during morning cares. The facility discussed the resident's chang in condition with the resident's primary care provider and medications were adjusted to reduce agitation. A progress note indicated the resident was extremely agitated the morning of the incident making it difficult to provide services. The resident was physically aggressive towards staff

During an interview, hospice unlicensed personnel (ULP)-2 said when she arrived at the resident's room, she observed her in bed covered with a blanket. When she removed the blanket, the resident was lying naked on a bare mattress. The resident was incontinent of urine. She said she gave the resident a bed bath and assisted with her usual cares. She said she never discussed her observation with the facility staff who worked on the shift. She reported the incident to the hospice nurse. She was unsure how long the resident was lying there.

During an interview, hospice nurse-3 said ULP-2 reported she found the resident incontinent of urine lying on her bed without sheets. She said the reddened area on the resident's buttocks area worsened due to the moisture. She was unsure how long the resident was lying there or if the ULP-2 reported the incident to facility staff. She brought up several other concerns including medication management and documentation to the facility leadership.

During an interview, a member of management said the resident was previously on hospice but had recently "graduated" (health improved and no longer required hospice services). ULP-2 reported, when she arrived, she observed the resident lying on her bare mattress naked and was incontinent of urine. The facility night shift ULP-1 reported he had recently been in the resident's room and assisted with changing her brief. The resident had been changed less than one hour before hospice ULP-2 arrived.

During an interview, facility nurse-1 said around the time of the incident the resident displayed increased agitation. The resident often removed her brief and tried to remove her clothing. The resident's primary care provider adjusted her medications to help her relax. Since the

medication adjustments the resident appeared more comfortable and stopped trying to remove her clothing and brief. The facility also increased the frequency of her safety checks and incontinence care schedule.

During an interview, nurse-2 said ULP-1 provided incontinent care to the resident and removed the sheet as it was soiled. When staff returned to apply fresh sheets, ULP-2 was already there. ULP-2 provided services to the resident and sheets were applied.

During an interview, a family member said nurse-3 was “overzealous.” He said communication between the hospice agency staff and the facility staff was lacking. Although he appreciated nurse-3’s efforts, he said she should have tried to work as a team with the facility rather than look for problems. He said the resident’s care suffered because of the issues between the hospice agency and the facility. He liked the staff at the facility and said the facility provided good care to the resident.

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 cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility completed an internal investigation and provided education to facility staff. The facility consulted with the residents’ primary care provider and medications were adjusted.

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

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
	31573	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF RAMSEY HILL	80 NORTH MACKUBIN STREET SAINT PAUL, MN 55102

(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: HL315737323C/HL315737482M On February 3, 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 54 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL315737323C/HL315737482M, tag identification 0730.	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.	
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the	0 730		

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0 730	Continued From page 1 following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution;	0 730		

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0 730	Continued From page 2 (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included all required content including documentation of complaints for one of one resident (R1) reviewed. This deficient practice had the potential to affect all residents. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 3, 2026, at 8:56 a.m., the investigator requested the facility's grievance log for the last six months. On February 3, 2026, at 9:20 a.m., residence director (RD)-A stated the facility had no documented grievances on file for the past six months. On February 3, 2026, at 11:55 a.m., director of nursing (DON)-B said she never completed grievance forms after receiving complaints. She denied she documented registered nurse	0 730		

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0 730	Continued From page 3 (RN)-F's concerns in R1s medical record. She never documented the concerns anywhere and was unaware if other staff had documented the concerns. On February 6, 2026, at 9:05 a.m., RN-F stated she reported numerous concerns to the facility. Her concerns included resident care issues and medication management in October 2025. R1 admitted to the licensee and began receiving services on January 17, 2024. R1's service plan dated January 6, 2025, indicated R1's services included assistance with all activities of daily living, transfers with a mechanical lift and medication administration. R1's progress notes dated June 5, 2025 through January 5, 2026 were reviewed. R1's record lacked complaints or reported concerns by RN-F. R1's records lacked documentation of complaint concerns and documentation of the licensee's resolution. On February 3, 2026, at 9:20 a.m., RD-A stated it was not the facility's practice to document grievances when a complaint was received. He said the facility had received many concerns/complaints from different people, but they never filed a grievance form. He said the facility addressed the concern but did not always document the concerns or resolutions anywhere. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		