Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306771960M
Compliance #: HL306777360C

Date Concluded: June 8, 2026

Name, Address, and County of Licensee Investigated:
Nine Mile Creek Senior Living
2301 Village Lane
Bloomington, MN 55431
Hennepin County

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

Evaluator's Name: Maerin Renee, 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 (AP), a facility staff member, neglected the resident when he assisted the resident to the toilet but did not assist the resident back from the toilet to his bed. Staff later found the resident with a bruise on his forehead and blood around his nose and on his hands. The resident was sent to the hospital and diagnosed with a forehead hematoma and bilateral nasal fractures (a broken nose).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident's care plan was followed at the time of the incident. The resident was assessed, sent to the hospital for evaluation and returned to his baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included review of the resident record, hospital records, the facility internal investigation, facility

incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff interactions with residents.

The resident resided in an assisted living facility memory care unit. The resident's diagnoses included dementia and osteoarthritis in both knees. The resident's service plan included reminders and cueing for some activities of daily living, escorts to meals, and medication management. The resident's assessment indicated he was independent with activities, eating, ambulation, bed mobility, and transfers.

The facility's internal investigation indicated the resident fell in an unknown location and broke his nose after being left unattended in the bathroom. The resident was sent to the hospital for further assessment. Staff were re-educated and the resident's service plan was updated.

Prior to the fall, the resident's service plan indicated he was independent with transfers, ambulation, and bed mobility. Staff were to change undergarments and provide peri care as needed. After the incident, the resident's service plan was updated and staff were instructed to stay with the resident while he was in the bathroom.

The resident's progress notes indicated the AP, while working the overnight shift, took the resident to the bathroom. The AP left the resident in the bathroom to provide scheduled care to another resident. The AP checked on the resident again at 5:50 a.m. and the resident was still in the bathroom. At 8:35 a.m., staff found the resident in bed with a large bump on the left side of his forehead and a small bump on the right side. There was an abrasion on his nose and dried blood on his left hand. The resident was sent to the hospital.

The resident's hospital record indicated he was treated for nasal fractures and a peri-orbital contusion (bruising of the skin and soft tissues around the eye). The resident was discharged back to the facility later that day in stable condition.

When interviewed, an administrator said the AP assisted the resident with an unscheduled bathroom service. The AP left the resident in the bathroom while he went to help another resident with a scheduled service. Later in the morning, a caregiver found the resident sleeping in bed, injured. The resident was assessed and sent to the hospital. The AP was re-educated and received corrective action. The resident returned to baseline health status.

When interviewed, a supervisor said the AP was performing a safety check for the resident when he helped him to the bathroom. The AP left to help another resident with a scheduled service. The AP returned to check on the resident, but he was still on the toilet. Soon after, another staff member found the resident sleeping in bed with an injury to his face. At the time of the fall, staff were encouraged but not required to stay with the resident while toileting because the resident would play with his feces if left alone. Since the incident, the resident's service plan was updated to instruct staff to stay with him in the bathroom.

When interviewed, the resident's family member said the resident liked to tell staff he could do everything himself even when he needed help. The resident also did not like to use his walker. The family member appreciated that the resident's service plan was updated with more detailed instructions for staff regarding toileting. The family member found the facility's staff to be very helpful and stated they were good at keeping her informed. Overall, the family member was happy with the care the resident received at the facility.

When interviewed, the AP said he worked the overnight shift and before morning shift change, he found the resident in the bathroom. The AP asked the resident if he was alright, and the resident said he was and did not need help. The AP left to assist another resident with a scheduled service. When the AP checked on the resident again, the resident was still in the bathroom. The AP left again to assist another resident with morning cares. The AP said there were no instructions at the time informing staff to stay in the bathroom with the resident; however, after the fall the service plan was updated, instructing staff to stay in the bathroom with 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, the resident's cognitive status prevented interview.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an investigation of the incident. The facility updated the resident's care plan and re-educated staff.
Action taken by the Minnesota Department of Health:
No further action taken 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
	30677	A. BUILDING: _____ B. WING _____	C 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NINE MILE CREEK SENIOR LIVING	2301 VILLAGE LANE BLOOMINGTON, MN 55431

(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 May 14, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL306777360C/#HL306771960M. No correction orders are issued.	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.	