Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308023143M
Compliance #: HL308022045C

Date Concluded: July 20, 2026

Name, Address, and County of Licensee Investigated:
Sterling Pointe Senior Living
1250 Northland Drive
Princeton, MN 55371
Mille Lacs County

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

Evaluator's Name:
Katherine Barnhardt RN, 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 resident neglected herself when the resident was found with an unexplained bruise and a fractured right clavicle (collarbone).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident had a history of falls with injury. Unlicensed staff observed and reported bruises on the resident's back and shoulder several times over several days. The resident had limited ability to raise her right arm and reported pain. After four days a facility nurse assessed the resident and sent her to the emergency room for evaluation.

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), death record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility

policy and procedures. Also, the investigator observed facility staff provide direct care to residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease and osteoporosis. The resident's service plan included assistance with safety checks, wandering, and toileting. The resident had difficulty finding words, was resistive to help from others and had impaired decision-making skills. The resident's assessment indicated the resident was ambulatory and did not require an assistive device for ambulation.

The resident's record indicated unlicensed staff observed and reported bruises on the resident's back and shoulder several times over several days. The resident had limited ability to raise her right arm and reported pain. The resident's record lacked information the resident was assessed by a licensed staff until the fourth day when the resident was sent to the emergency room for evaluation. The resident's record indicated the resident sustained a fractured right clavicle. Additionally, the resident's record indicated within approximately two months after the clavicle fracture the resident had a fall that resulted in a hip fracture.

Progress notes indicated a licensed staff documented the resident reported shoulder pain. The next day an unlicensed staff documented observation of a bruise on the resident's right shoulder, and the resident repeatedly stated her shoulder hurt while rubbing it. Four days later an unlicensed staff requested licensed staff assess the resident because the resident continued to complain of pain in the right shoulder and was unable to raise her right arm. Progress notes indicated after four days a licensed staff noted a bruise present from the resident's back, up and over the right shoulder and down towards the resident's right chest region. Progress notes indicated the top of the resident's left hand was swollen. The resident was transported to an emergency room by a family member.

Hospital records indicated the resident presented with a large, bruised area over the right shoulder and clavicle and a swollen left hand. X-rays indicated the resident had a mid-clavicle fracture on the right side that was non-operable, and the left hand was free of fractures. A sling was unable to be used for treatment due to the resident's cognitive status. Hospital records indicated the resident returned to the facility the same night with recommendations for a higher level of care.

Review of medical records indicated within approximately two months after the clavicle fracture the resident had a fall that resulted in a fractured hip. The resident's record failed to include change of condition assessments or documentation that the licensed staff reviewed fall injuries or implemented changes to the resident's plan of care to address falls. The resident's assessments did not accurately depict the resident's health status or needs.

During an interview, licensed staff stated unlicensed staff reported the resident had pain, a large bruise and difficulty moving her right shoulder that had been present for a couple days. Licensed staff found a large, swollen bruise on the resident's right shoulder and the resident

reported pain and difficulty moving her right arm. Licensed staff reviewed notes and found other licensed staff had been told earlier about the bruising, however failed to assess the resident's pain and limited right arm mobility. Licensed staff stated there were no change in condition assessments done.

During an interview, unlicensed staff stated the resident was combative with cares, wandered the memory care unit and often went into other resident's rooms. Unlicensed staff stated the resident had a lot of unwitnessed falls.

During an interview, a family member stated the resident started having falls when she admitted to the facility and as the falls became worse family got concerned. A family member stated facility staff were unsure how the resident's fracture occurred, and family did not feel the resident was safe at the facility. The resident's family met with the facility after the clavicle fracture however, fall interventions were not changed or implemented. A family member stated the resident had a lot of falls before her death.

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: No, deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility sent the resident to the emergency room for an evaluation of shoulder pain.

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
Mille Lacs County Attorney
Princeton City Attorney
Princeton Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30802	A. BUILDING: _____ B. WING _____	C 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING POINTE SENIOR LIVING	1250 NORTHLAND DRIVE PRINCETON, MN 55371

(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: #HL308023143M/#HL308022045C On June 23, 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 55 residents receiving services under the Assisted Living license. The following correction orders are issued for #HL308023143M/#HL308022045C, tag identification 1620 and 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.	
01620 SS=H	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30802	A. BUILDING: _____ B. WING _____	C 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING POINTE SENIOR LIVING	1250 NORTHLAND DRIVE PRINCETON, MN 55371

(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
01620	Continued From page 1 (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30802	A. BUILDING: _____ B. WING _____	C 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING POINTE SENIOR LIVING	1250 NORTHLAND DRIVE PRINCETON, MN 55371

(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
01620	Continued From page 2 the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to a suitable and up-to-date plan, and subject to acceptable health care and medical, or nursing standards for three of three residents (R1, R2, R3) reviewed for falls. The licensee failed to ensure injuries were assessed, monitored and/or resolved and failed to develop and implement new interventions related to the root cause of the falls. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's admitted to the facility on November 17, 2025, with diagnoses which included Alzheimer's	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30802	A. BUILDING: _____ B. WING _____	C 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING POINTE SENIOR LIVING	1250 NORTHLAND DRIVE PRINCETON, MN 55371

(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
01620	Continued From page 3 disease and osteoporosis. R1's unsigned service plan dated June 4, 2026, indicated R1 received assistance with dressing, grooming, toileting, medication administration and behavioral management. R1's 90-day assessment dated March 10, 2026, indicated R1was seen at an emergency room for a laceration post fall and R1 did not use assistive devices for ambulation. R1's assessment indicated R1 had one to two falls in the previous 90-days, and a nurse would review R1's assessment with a change in condition. R1's assessment dated June 4, 2026, indicated R1 admitted for hospice services, however, R1's assessments did not address fall interventions even though R1 sustained a clavicle fracture and a hip fracture because of two separate unwitnessed falls approximately six weeks apart. R1's progress notes indicated from April 22, 2026, through April 25, 2026, R1 reported daily pain in her right shoulder and the inability to raise her arm. On April 25, 2026, unlicensed personnel requested licensed personnel assess the resident and significant bruising was observed on R1's right shoulder and back. Progress notes indicated R1 was transported to an emergency department and diagnosed with a right clavicle fracture. Progress notes indicated R1 admitted to hospice on June 1, 2026, and unlicensed personnel found R1 on the bathroom floor June 8, 2026. A licensed hospice nurse went to the facility, assessed R1and suspected a fractured hip. Progress notes indicated R1 expressed pain with repositioning and remained in bed until her death on June 14, 2026. R1's record lacked change of condition	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30802	A. BUILDING: _____ B. WING _____	C 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING POINTE SENIOR LIVING	1250 NORTHLAND DRIVE PRINCETON, MN 55371

(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
01620	Continued From page 4 assessments completed by facility registered nurses. R2 R2 admitted to the facility on March 24, 2025, with diagnoses which included dementia and non-Hodgkin lymphoma (cancer). R2's service plan dated June 16, 2026, indicated R2 received assistance with dressing, toileting, transfers with two staff and a mechanical lift and oxygen supplemental use. R2's assessment labeled hospice admission and dated April 7, 2026, indicated R2 had one to two falls in the previous three months and was ambulatory without assistive devices. R2's fall detail report indicated from May 14, 2026, through May 30, 2026, R2 had six falls. R2's progress notes May 14, 2026, through May 30, 2026, indicated falls and the following: - May 14, 2026, at 12:27 a.m., fall, small rug burn on left leg, request for facility nurse to please follow up; - May 14, 2026, at 10:40 a.m., fall, resident found on floor on knees requesting assistance up; - May 14, 2026, at 11:27 a.m., unwitnessed fall, unsing 4 wheeled walker, brakes not locked. Resident on buttocks with left leg out front and right leg ent behind table leg; - May 14, 2026, at 9:47 p.m., unwitnessed severe fall, large forehead laceration, bleeding, goose egg on left cheek, fallen multiple times today. On Eliquis (blood thinner). Vital signs not obtained. Resident found lying on stomach compromising airway;	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30802	A. BUILDING: _____ B. WING _____	C 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING POINTE SENIOR LIVING	1250 NORTHLAND DRIVE PRINCETON, MN 55371

(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
01620	Continued From page 5 - May 15, 2026, at 8:25 p.m., unwitnessed fall, resident found on floor, laceration above left eye bleeding, complaint of left shoulder pain. Laceration on right hand; - May 30, 2026, at 1:35 p.m., unwitnessed fall, resident found on floor, no assistive devices used, motion sensor did not alert. On June 23, 2026, at 11:22 a.m., investigators observed unlicensed personnel transfer and toilet R2 with a mechanical device and push R2 in his manual wheelchair to lunch. R2's record lacked an updated accurate assessment and change in condition assessments when falls with injuries occurred. R3 R3 admitted to the facility on February 17, 2025, with diagnoses which included dementia and diaphragmatic hernia (abdominal organs move into chest through abnormal opening in diaghram). R3's unsigned service plan dated May 31, 2026, indicated R3's services included bathing, dressing, grooming, toileting, transfers and ambulation. R3's 90-day assessment dated May 26, 2026, indicated R3 had multiple falls during the previous 90-days and was unsafe with independent ambulation. R3's hospice referral assessment dated May 31, 2026, indicated R3 was at risk for falls and had fallen four times in the prior three months. The assessment indicated R3 required enhanced needs with observations and fall management.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30802	A. BUILDING: _____ B. WING _____	C 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING POINTE SENIOR LIVING	1250 NORTHLAND DRIVE PRINCETON, MN 55371

(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
01620	Continued From page 6 R3's progress notes indicated the following falls that resulted in a change in condition and/or changes in condition: - April 10, 2026, at 10:59 a.m., increased lethargy, sweaty, heart rate 105, blood pressure 97/44, and oxygen saturation level 88-89% on room air. Hospice updated on change of condition and nurse would be sent out for a visit; - April 30, 2026, at 4:00 a.m., unwitnessed fall, R3 found on floor wrapped in bedding when safety check done. Hospice updated and will be out sometime today; - May 14, 2026, at 5:54 p.m., unwitnessed fall, R3 fell backward on buttocks and elbows. R3 reported buttocks and both knees sore. - May 15, 2026, at 10:03 p.m., unwitnessed fall, R3 fell by dining room. Hospice updated and will send nurse out to assess. Facility staff got R3 off floor prior to calling after hours nurse. - May 19, 2026, at 7:17 p.m., unwitnessed fall, R3 fell in common living room. R3 found sitting on her bottom. Hospice notified, will send a nurse out. - May 20, 2026, 2:02 p.m., R3 complaints of right wrist pain and reported fall. Multiple falls yesterday. Reports pain to right elbow and left arm. Facility nursing updated. R3's record lacked change in condition assessments completed by a facility registered nurse. During an interview, dated June 25, 2026, at 7:33 a.m., licensed practical nurse (LPN)-C stated if falls occur after hours triage is called for advice, if falls occur during business hours facility nurses are called to assess, and complete reports. During an interview dated June 29, 2026, at 10:06 a.m., assistant director of health services	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30802	A. BUILDING: _____ B. WING _____	C 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING POINTE SENIOR LIVING	1250 NORTHLAND DRIVE PRINCETON, MN 55371

(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
01620	Continued From page 7 (ADON)-B stated when residents fall a nurse completes a head-to-toe assessment, everything is documented, and the primary care provider is notified. ADON-B stated she had attempted to assess R1's shoulder injury. ADON-B stated R1 did not have a change in condition assessment completed. During an interview, dated June 30, 2026, at 10:33 a.m., unlicensed personnel (ULP)-E stated when residents fell, ULP's stayed with the resident and requested a nurse, if there was not a nurse onsite ULP's called triage for direction. If a fall was "really bad", hospice would be called right away and ULP's would follow hospice direction. During an interview, dated July 6, 2026, at 11:03 a.m., licensed assisted living director (LALD)-A stated when there were changes in condition a nursing team provided assessments to review a need for increased cares or support. The licensee's Fall Risk Mitigation and Response Policy dated December 2025, indicated the purpose of the policy was to ensure adequate interventions were in place to decrease, limit and mitigate resident falls and ensure resident safety. Licensed staff would implement fall mitigation interventions appropriate to the perceived reason/root cause of the fall and document in the resident's service plan. The licensee's Minnesota Clinical Assessment Guide AL and MC policy dated May 2024, indicated a nursing assessment would be completed with a change in condition and a post fall review completed after every fall. No further information was provided.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30802	A. BUILDING: _____ B. WING _____	C 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING POINTE SENIOR LIVING	1250 NORTHLAND DRIVE PRINCETON, MN 55371

(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
01620	Continued From page 8 TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
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 covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of three residents reviewed (R1) was free from maltreatment. Findings include: On June 23, 2026, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		