Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL312728542M
Compliance #: HL312721460C

Date Concluded: March 24, 2026

Name, Address, and County of Licensee Investigated:
Croixdale
750 Highway 95 North
Bayport, MN 55003
Washington County

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

Evaluator's Name: Brandon Martfeld, RN, BSN, 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 the resident sustained fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident independently exited his apartment and fell against a doorway. Although the AP did not follow the facility's protocol after the resident fell, there was not a preponderance of evidence to indicate the AP's actions or inactions caused the resident's left shoulder blade fracture. The resident was sent to the hospital for an evaluation and returned to the facility.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, facility camera footage, personnel files,

staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease and abnormalities of gait and mobility. The resident's service plan included assistance with morning and evening care, and staff were to escort the resident to activities. The resident's assessment indicated the resident had cognitive impairment, required supervision with ambulation, and used a walker.

The facility camera footage showed the resident walking out of his apartment into the hallway while using his walker independently. As the resident came through his apartment doorway, the resident fell to his left side, hitting the back of his left shoulder against the bottom of an adjacent doorway and landing on his left elbow. The resident rolled himself onto his right side and then onto his back. After one minute and 10 seconds, the AP came to the side of the resident. The AP took the resident by his hands and pulled him up to a seated position. After a few seconds the resident rolled back onto his back. While standing behind the resident, the AP pushed the resident back into a seated position and placed her right knee into the back of the resident. Then the AP assisted the resident onto his hands and knees and then left the frame of the camera footage. After a few seconds, the AP returned to the frame of the camera footage with a chair and positioned the chair in front of the resident facing towards him. The AP assisted the resident into a standing position, placed the resident's walker next to him and resident grabbed the walker. The AP assisted the resident back into his apartment. After a few seconds, the AP walked out of the resident's apartment and down the hallway away from the resident's apartment.

The resident's medical record indicated that the resident self-reported a fall to a different staff member and the facility's camera footage was reviewed. The resident was assessed and was found with an abrasion on his left knee and severe left shoulder pain. The resident's provider ordered an x-ray. As the day went on, the resident had unrelieved shoulder pain, the on-call nurse was notified, and the resident was sent to the hospital via emergency medical services.

The hospital record indicated the resident presented to the hospital with left shoulder pain. The resident had a computed tomography (CT) scan completed and it revealed the resident had a non-displaced left shoulder blade (scapula) fracture. The resident's left arm was placed in a sling and was discharged back to the facility.

During an interview, unlicensed staff member stated a nurse was notified after the resident reported he fell into the doorway and hit his shoulder.

During an interview, a nurse stated towards the end of the AP's shift, the resident fell. The AP assisted the resident off the floor and back into this room. The AP did follow the facility's fall protocol and did not report the fall appropriately. Another staff member went into the resident's room, and the resident reported that he fell. An assessment and an x-ray were

completed on the resident. Initially the x-ray indicated the resident did not have a fracture, but as the day went on, the resident's pain was unrelieved. Late in the evening the resident was transferred to the hospital for an evaluation. The hospital determined the resident had fractured his left shoulder blade, placed his arm in a sling and the resident returned to the facility. The nurse stated the AP had reported and followed the facility's fall protocol appropriately during previous falls of other residents. A nurse stated during her investigation she interviewed the AP who stated she thought if the resident could get up, she did not have to report the fall. The nurse stated education was completed with all staff that when a resident falls a nurse is to be notified, vital signs are to be completed on the resident, and two staff are to use a mechanical lift to get the resident off the floor, unless the resident can get up off the floor without any staff assistance.

During an interview, a family member stated after the resident fell, he went to the hospital for a few hours. The resident returned to the facility, had his left arm placed in a sling, and the fractured healed. The family member stated the resident worked with therapy and the resident's left arm was stronger than it ever had been.

The AP did not respond to interview requests.

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 cognitive impairment, the resident as not able to be interviewed.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No. Several attempts to interview the AP were made unsuccessfully.

Action taken by facility:

The resident was transferred to the hospital for an evaluation, treated and returned to the facility. Staff education was completed regarding the facility's fall protocol. The AP is no longer employed by the facility.

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
	31272	A. BUILDING: _____ B. WING _____	C 03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROIXDALE	850 HIGHWAY 95 NORTH BAYPORT, MN 55003

(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 March 16, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL312728542M / #HL312721460C. No correction orders are issued.	0 000		