Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL397175562M
Compliance #: HL397173143C

Date Concluded: November 4, 2025

Name, Address, and County of Licensee Investigated:
Living Hope Homes Eagles View
2904 Cooper ave south
St. Cloud, MN 56301
Stearns County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lena Gangestad, 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 he choked and passed away at the dining table. The resident had been prescribed a soft food diet, but his place setting included whole green grapes, whole cherry tomatoes, and a cut-up chicken sandwich.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The facility responded appropriately when the resident was found unresponsive at the dining room table food was removed from his mouth but there was no obstruction found. The death certificate for the resident indicated he died of cardiac arrest. However, a correction order for compliance was issued for a lapse in supervision during the meal.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, internal investigation documentation, incident reports, staff schedules, policies, and procedures.

The resident lived in an assisted living facility. His diagnoses included congenital hydrocephalus and cerebral palsy. His service plan indicated he required assistance with all activities of daily living. Due to dysphagia (difficulty swallowing), the resident had a special diet.

Around lunchtime, staff noticed the resident appeared unwell, with his head tilted as if he were sleeping at the table. He was drooling, and his mouth was not moving. Staff patted his shoulder, but he was unresponsive. They lowered him to the floor and began chest compressions. Emergency services arrived shortly afterward. As the resident had a Do Not Resuscitate (DNR) order, compressions were stopped, and he passed away.

A nurse's report from a home care visit indicated that the resident's diet was mechanical soft with chopped meats and thin liquids. It also indicated that the resident was downgraded to minced and moistened solids due to worsening dysphagia.

The spring menu listed the lunch on the day of the incident as a chicken patty on a bun, French fries, and fruit.

During an interview, an unlicensed caregiver stated the resident required a full Hoyer lift transfer and was able to use his right arm. The unlicensed caregiver state he could feed himself, but only with supervision, meaning staff needed to be present when he ate. His prescribed diet was minced and moist. On the day of the incident, staff assisted him into the dining room, where he sat across from Resident #2. His meal included fries, a cut up chicken sandwich, and cut-up banana. Another resident had grapes, and there were tomatoes on the table. Resident #2 attempted to share food with the resident, but the caregiver told her she could not share her food with the resident. The caregiver said she left the dining room to administer scheduled medication around noon for another resident, while another caregiver remained in the room. When she returned to put away the insulin pen, Resident #2 told her something was wrong. She looked over and saw the resident slumped as if sleeping, which was not unusual for him. She said another caregiver was either in the bathroom or taking out the trash at the time. On closer inspection, she noticed that his coloration was off. She attempted to wake him but realized he was not breathing. She checked his pulse but could not detect breathing or chest movement. At that point, 911 was called. The resident was lowered to the floor, and food was cleared from his mouth before chest compression began. She stated that the food she removed was chewed and that nothing was lodged in his throat. The caregiver estimated she was away from the dining room for three to four minutes, during which another caregiver had been present. However, she was unsure how long he had been unattended before she returned.

During an interview, the resident #2 stated that she was sitting across from the resident during the meal. She observed that at one point he looked at her, then his head began to lean over. His eyes were open, but he was not breathing. She stated that no staff were in the room at that time, only herself and the resident. She called for help, and staff responded.

During an interview, the nurse stated the resident required a Hoyer lift with two staff and used an electric wheelchair. His prescribed diet was minced and moist texture with thin liquids. He could use his right hand to eat but not his left, and he required supervision at all times during meals. She said that she was across the street at another house when the staff notified her. When she arrived, the resident was in his chair, blue, non-responsive, and without a pulse.

During an interview, a family stated the resident had been at the facility for about five months. Th family member stated she frequently visited at mealtimes because he needed supervision while eating. She reported that he had difficulty chewing and needed reminders to slow down. Despite his soft diet order, she stated that the facility primarily served him sandwiches. She also stated that staff were supposed to sit next to him while he ate, but no one was present with him at mealtime most of the time.

During an interview, the manager stated she was not present during the incident. She reported the resident's diet was regular with minced and moist texture. On that day, he was served a cut-up chicken patty sandwich, fries, and cut-up banana. She stated that the resident could use his right hand and ate independently. According to her, the resident sitting across from him notified staff because he looked unwell. Staff then notified the nurse and called 911. The manager confirmed that, according to his care plan, the resident required supervision while eating.

A death certificate indicated the cause of death was cardiac arrest and did not include choking as part of the cause of death.

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

Action taken by facility: The facility called 911 and reported the incident to the Minnesota's Adult Protective Services.

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
	39717	A. BUILDING: _____ B. WING _____	C 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES EAGLES VIEW	2904 COOPER AVENUE SOUTH SAINT CLOUD, MN 56301

(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 September 4th, 2025, the Minnesota Department of Health initiated an investigation of complaint HL397175022M/HL397171345C, and HL397175562M/HL397173143C . The following correction orders are issued For HL397175022M/HL397171345C,the following correction order is issued, tag identification 2360. For HL397175562M/HL397173143C, the following correction order is issued, tag identification 1640.	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.	
01640 SS=G	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39717	A. BUILDING: _____ B. WING _____	C 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES EAGLES VIEW	2904 COOPER AVENUE SOUTH SAINT CLOUD, MN 56301

(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
01640	Continued From page 1 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee did not implement the care plan for one of one resident (R1) reviewed when the facility did not ensure supervision during a meal and no staff member was in the dining room during a meal. The correction order was issued at a level 3 as 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 or a	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39717	A. BUILDING: _____ B. WING _____	C 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES EAGLES VIEW	2904 COOPER AVENUE SOUTH SAINT CLOUD, MN 56301

(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
01640	Continued From page 2 violation that had the potential to cause more than minimal harm to the resident; and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally) The findings include: R1's medical record indicated R1 admitted to the facility on March 19, 2025, with diagnoses of congenital hydrocephalus and cerebral palsy. R1's service plan, dated July 5, 2025, indicated R1's prescribed diet consisted of minced and moist foods with thin liquids. The same document indicated R1 required supervision during food and liquid intake due to swallowing difficulties, specifically a history of choking episodes. An incident report dated August 20, 2025, at 12:10 p.m., indicated R1 was eating a lunch meal included a chicken patty on a bun with cheese, lettuce, and mayonnaise, along with French fries with ketchup and a slice of banana. At the time, unlicensed caregiver (ULP-C) was in another resident's room administering medication, while ULP-F was in the bathroom and subsequently went out to dispose of garbage in the garage. R2 alerted staff R1 did not appear well. ULP-F responded, observed R1 showed discoloration and appeared not to be breathing, and immediately intervened. ULP-C obtained an oximeter and a glove to check R1's mouth and oxygen status. Emergency medical services (EMS) were called, and chest compressions were initiated until EMS arrived. On September 22, 2025, at 11:26 a.m., ULP-C	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39717	A. BUILDING: _____ B. WING _____	C 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES EAGLES VIEW	2904 COOPER AVENUE SOUTH SAINT CLOUD, MN 56301

(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
01640	Continued From page 3 stated R1 required a full Hoyer lift transfer and was able to use his right arm. R1 could feed himself, but only with supervision, meaning staff needed to be present when he ate. His prescribed diet was minced and moist. On the day of the incident, ULP-C and ULP-F assisted him into the dining room, where he sat across from R2. His meal included fries, a cut up chicken sandwich, and cut-up banana. R2 had grapes, and there were tomatoes on the table. R2 attempted to share food with him, but ULP-C told her no. ULP-C said she left the dining room to administer scheduled medication around noon for another resident, while ULP-F remained in the room. When ULP-C returned to put away the insulin pen, R2 told her something was wrong with R1. She looked over and saw R1 slumped as if sleeping, which was not unusual for him. She said ULP-F was either in the bathroom or taking out the trash at the time. On closer inspection, ULP-C noticed that R1's coloration was off. She attempted to wake R1 but realized R1 was not breathing. She checked his pulse but could not detect breathing or chest movement. At that point, 911 was called. R1 was lowered to the floor, and food was cleared from his mouth before chest compression began. She stated that the food she removed was chewed and that nothing was lodged in R1's throat. ULP-C estimated she was away from the dining room for three to four minutes, during which ULP-F had been present. However, she was unsure how long he had been unattended before she returned. On September 16, 2025, at 1:00 p.m., R2 stated that she was sitting across fromR1 during the meal. She observed that at one point R1 looked at her, then his head began to lean over. His	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39717	A. BUILDING: _____ B. WING _____	C 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES EAGLES VIEW	2904 COOPER AVENUE SOUTH SAINT CLOUD, MN 56301

(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
01640	Continued From page 4 eyes were open, but he was not breathing. She stated that no staff were in the room at that time, only herself and R1. She called for help, and staff responded. On September 22, 2025, at 11:51 a.m., clinical manager (CM)-D stated R1 required a Hoyer lift with two staff and used an electric wheelchair. R1's prescribed diet was minced and moist texture with thin liquids. R1 could use his right hand to eat but not his left, and he required supervision at all times during meals. CM-D said that she was across the street at another house when the staff notified her. When she arrived, R1 was in his chair, blue, non-responsive, and without a pulse. On September 16, 2025, at 12:37 p.m., the manager (LALD)-A stated that she was not present during the incident. She said R1's diet was regular with minced and moist texture. On that day, R1 was served a cut-up chicken patty sandwich, fries, and cut-up banana. She stated that R1 could use his right hand and ate independently. According to her, R2 sitting across from him notified staff because he looked unwell. Staff then notified the nurse and called 911. (LALD)-A confirmed that, according to his care plan, the resident required supervision while eating. On September 16, 2025, at 10:46 a.m., the family member (FM)-E stated that R1 had been at the facility for about five months. She frequently visited at mealtimes because he needed supervision while eating. (FM)-E said that R1 had difficulty chewing and needed reminders to slow down. Despite his soft diet order, she stated that the facility primarily served him sandwiches.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39717	A. BUILDING: _____ B. WING _____	C 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES EAGLES VIEW	2904 COOPER AVENUE SOUTH SAINT CLOUD, MN 56301

(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
01640	Continued From page 5 (FM)-E also stated that staff were supposed to sit next to him while he ate, but no one was present with him at mealtime most of the time. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
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: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual alleged perpetrator was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	