Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL397185902M
Compliance #: HL397183844C

Date Concluded: December 10, 2025

Name, Address, and County of Licensee Investigated:
Living Hope Homes Oak Grove
1805 60th Street East
Inver Grove Heights, MN 55077
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: James P. Larson, RN
Special Investigator
Brooke Anderson, 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 facility neglected the resident when the resident was sent to the hospital for a change in condition related to a fever and was found to have a stage three pressure ulcer.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. When the facility identified a skin concern on the resident's coccyx no new interventions were put into place and the provider was not updated. Additionally, facility staff did not provide necessary care to promote healing and/or prevent worsening of the resident's pressure ulcer and reduce the risk of further skin breakdown.

The investigator conducted interviews with facility staff members including nursing staff and contacted a family member. The investigation included review of the resident's records, facility

internal documentation, as well as related facility policies and procedures. The investigator toured the facility, observed staff interacting with residents and completing scheduled care activities at the time of the onsite visit.

The resident resided in an assisted living facility. The resident's diagnoses included spinal stenosis, Type 2 Diabetes, and Transient Ischemic Attack (TIA). The resident's service plan included assistance with incontinence care and repositioning every three hours. The resident's assessment indicated that the resident required staff assistance for all movements, used an electric wheelchair, and had a history of skin concerns including a scar on her coccyx (tailbone) area.

Review of medical records indicated the resident has a history of spinal surgeries that have made movement increasingly difficult, rendering the resident bedbound. A progress note indicated the resident had thickened scar tissue, but no open areas were noted. Approximately two weeks later a progress note indicated the resident had complaints of pain in her coccyx. The progress note indicated the resident had denuded skin (the skin's surface layers are removed, exposing raw, damaged tissue). The facility nurse applied a cream to the site and offloaded the resident off her coccyx. Facility staff were reminded to continue to offload the resident and follow her toileting plan. Approximately four days later the resident had complaints of pain in her coccyx and was sent to the emergency room.

Hospital records indicated the resident was evaluated for a urinary tract infection and tailbone pain. Upon examination of the resident's back a full-thickness pressure wound was found on the resident's coccyx. The resident was treated with an antibiotic and discharged back to the facility.

Provider records indicated the resident was seen by the provider after the resident was discharged from the hospital. The provider ordered an outside agency nurse to manage the resident's stage 3 pressure ulcer.

Review of medical records indicated in the weeks prior to the hospitalization on approximately forty separate occasions facility staff failed to document if scheduled repositioning of the resident had occurred. During that time, an additional five occasions entries in the service record indicated that the resident had refused or declined to be repositioned. Medical records lacked evidence the facility nurse was notified that the resident was refusing cares or of follow up was completed. The facility did not ensured services were provided by facility staff as scheduled and did not update the provider when the condition of the wound got declined.

During an interview a former facility staff stated she was gone from the facility for two weeks and when she came back, she was concerned the resident had the pressure sore. The resident was supposed to be turned every two hours or when she called for staff assistance. The interventions were in place to prevent sores. A former facility stated she reported the concerns to facility management.

During an interview, a nurse stated the resident had a history of skin concerns on her coccyx and had a prior injury related to repositioning. Facility staff were educated to turn and reposition the resident due to the concerns with skin integrity and were aware she needed to be repositioned. Facility staff were to document when the service was provided and if the resident refused a care the staff were trained to talk with the resident and learn why the resident was refusing, document the refusal and reapproach later. Nurses were alerted to change in the resident by reviewing shift reports. A facility nurse stated since the hospitalization the facility had implemented additional interventions to heal and prevent further pressure ulcers.

During an interview, a family member stated that they had no prior concerns of the care provided at the facility during the previous years that the resident had resided at the facility. When they were told the resident had the pressure sore the family provided specialized medical equipment, body positioning wedges, wheelchair pads, and air mattresses to aide in healing. They had concerns over the formation of the sore to facility staff and indicated that they would be planning to discharge the resident.

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

Action taken by facility:
On going education was provided to facility staff. The facility contacted the resident’s primary care provider to re-assess the need for updated care orders.

Action taken by the Minnesota Department of Health:

The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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
You may also call 651-201-4200 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Dakota County Attorney
Eagan City Attorney
Eagan Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39718	A. BUILDING: _____ B. WING _____	C 11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES OAK GROVE	1805 60TH STREET EAST INVER GROVE HEIGHTS, MN 55077

(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: #HL397183844C/#HL397185902M On November 13, 2025, 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 5 residents receiving services Under the provider ' s Assisted Living license. The following correction order is issued/orders are issued for ##HL397183844C/#HL397185902M, tag identification 2360.	0 000		
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.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	Assisted Living Provider 144G. 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.	

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