Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Project: HL253104803M
Compliance Project: HL253101004C

Date Concluded: November 3, 2025

Name, Address, and County of Licensee Investigated:
Stonecrest
8725 Promenade Lane
Woodbury, MN 55125
Washington County

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

Evaluator's Name: Deb Schillinger 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 unlicensed caregiver, neglected the resident when the on-call nurse was not notified again after a fall when the resident reported she could not feel her legs.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The resident had a fall at about 3 a.m. on the night shift and the AP, along with another unlicensed caregiver provided assistance. At that time, the resident had no complaint of leg numbness. Later the resident said she could not feel her legs, the AP offered repositioning which the resident said was helpful. However, by 8 a.m. in the morning the resident had developed persistent leg numbness and was transferred to the hospital.

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

files, staff schedules, and related facility policy and procedures. Also, the investigator observed interactions between residents and facility staff during an onsite visit.

The resident resided in an assisted living memory care unit. The resident's diagnoses included mild dementia, bradycardia and type 2 diabetes with peripheral neuropathy (nerve damage that leads to numbness, pain or weakness in the hands and feet). The resident's service plan included assistance with medication management and administration, toileting assistance and showering. The resident's assessment indicated the resident was able to make her needs known and ambulated with a walker.-

A concern arose when the resident had an unwitnessed fall and later developed numbness secondary to a spinal fracture.

A facility incident report indicated the resident was found on the floor in her room after an unwitnessed fall on the night shift around 3 a.m. After the fall, the resident pushed her pendant to alert caregivers and told the AP and another unlicensed caregiver she had fallen while returning to bed after using the bathroom. The documentation indicated the resident's legs were not twisted or turned, but the resident reported shoulder and arm pain. The incident report did not indicate other symptoms or concerns.

A facility internal investigation indicated after the fall the on-call nurse was notified and relayed the resident had fallen, denied hitting her head and range of motion was intact. The on-call nurse was told the resident complained of left shoulder and right arm pain. The nurse instructed the unlicensed caregivers to lift off the floor using the mechanical lift and give as needed Tylenol for pain. Later the AP returned to check on the resident, who reportedly said her legs were feeling numb.

Around 8 am when the nurse arrived, she assessed the resident who was now reporting an inability to move her legs and thought her legs were crossed when her legs were not crossed. The report indicated the resident thought she could feel the nurse touching her legs and was able to move feet very little when instructed by nurse. The resident was then transferred by emergency medical services (EMS) to the hospital for evaluation where she was diagnosed with a spinal fracture.

During an interview, the AP reported after the on-call nurse gave directions to get the resident up off the floor using the mechanical lift, the resident was helping them roll her from side to side to get the sling for the lift underneath her and the resident was moving her legs. Once they were able to get the resident back in her bed, she gave Tylenol for the resident's report of pain. The AP stated later in the shift the resident said she could not feel her legs and offered to reposition of legs with a pillow and the resident stated it was better, so she did not call the on-call nurse. The AP stated she asked her fellow unlicensed caregiver working with her to call the nurse and write the incident report because she is not as fluent in the English language.

During an interview, the unlicensed caregiver reported she assisted the AP after the resident's fall and filled out the incident report. The unlicensed caregiver stated the AP did not relay changes in the resident's condition later in the shift.

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.
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: No, is deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: Education and retraining provided to all staff in regard to identifying change in conditions.

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
	25310	A. BUILDING: _____ B. WING _____	C 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONECREST	8725 PROMENADE LANE WOODBURY, MN 55125

(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 August 20, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL253101004C /#HL253104803M. No correction orders are issued.	0 000		