Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL285582881M
Compliance #: HL285581355C

Date Concluded: April 28, 2026

Name, Address, and County of Licensee Investigated:
The James Inc
10549 Beard Avenue South
Bloomington, MN 55431
Hennepin County

Facility Type: Assisted Living Facility (ALF)

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 facility neglected resident #1, resident #2, resident #3, resident #4, resident #5 and resident #6 when they failed to complete interventions when resident #1 had behaviors.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to provide supervision to protect residents (resident #1, resident #2, resident #3, resident #4, resident #5 and resident #6). The facility was aware resident #1 exhibited violent and aggressive behaviors and failed to identify and implement interventions to mitigate future incidents. The facility failed to supervise, assess and implement interventions to protect the health and safety of resident #1, resident #2, resident #3, resident #4, resident #5 and resident #6.

The investigator conducted interviews with unlicensed staff, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, fire department, case managers, and a pharmacy. The investigation included review of the resident record(s), hospital records, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement reports, fire department reports, related facility policy and procedures. Also, the investigator observed the facility's staff interact with residents.

Resident #1 resided in an assisted living facility. The resident's diagnoses included borderline personality disorder, anxiety, paraplegia, and a left buttock wound. The resident's service plan included assistance with behavior management. Resident #1's assessment indicated he was alert and oriented and had a history of abusive, destructive and violent behavior. Resident #1's individual abuse prevention plan (IAPP) indicated concern for unsafe smoking, and risk of abusing self and others.

Resident #2 resided in an assisted living facility. The resident's diagnoses included schizophrenia and psychosis. Resident #2's service plan included assistance with behavior management and medication management. Resident #2's assessment indicated he was alert and oriented and was vulnerable to being abused by others.

Resident #3 resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder, cognitive impairment and substance abuse. Resident #3's service plan included assistance with behavior management and medication administration. Resident #3's assessment indicated he had poor decision-making, delusions, hallucinations and was at risk of being abused by others.

Resident #4 resided in an assisted living facility. The resident's diagnoses included bipolar disorder, polysubstance dependence and anxiety. Resident #4's service plan included assistance with behavior management and medication administration. Resident #4's assessment indicated he was alert, confused and at risk of being abused by others.

Resident #5 resided in an assisted living facility. The resident's diagnoses included bipolar disorder and substance abuse dependence. Resident #5's service plan included assistance with behavior management and medication administration. Resident's #5's assessment indicated she was alert, forgetful and was at risk of being abused by others.

Resident #6 resided in an assisted living facility. The resident's diagnoses included schizophrenia. The resident's service plan included assistance with behavior management and medication administration. Resident #6's assessment indicated he was alert, forgetful, had delusions and was at risk of being abused.

Review of facility documents including photos and videos indicated resident #1 had moved into the facility and over a three-month time frame several incidents were documented including but not limited to the following:

While staff were outside shoveling snow, resident #1 exited the facility with a fire extinguisher and was "playing" with it in the snow. Resident #1 had pulled the fire extinguisher out of the wall. When resident #1 was asked why he did that, resident #1 laughed at the staff. Resident #1 then went into the facility and told the other residents you all should leave and go to a family place because something is about to happen here and it's going to be a surprise.

Resident #1 entered the kitchen with a urinal and poured urine on the floor. When resident #1 was asked why he did that, resident #1 laughed and exited the facility.

A photo showed urine pooled on the kitchen floor and a kitchen base cabinet door broke off.

A photo showed feces smeared on the kitchen refrigerator and condiments sprayed on cabinets, kitchen appliances, walls, ceiling and a glass door.

A video with audio showed condiments sprayed across cabinets, the kitchen floor, and a smoke alarm alerting. Resident #1 cut the lock off the medication cabinet. A unlicensed staff attempted to block resident #1's access to the medication cabinet. Resident #1 lit a cigarette to smoke in the kitchen area next to the unlicensed staff and blew cigarette smoke into the unlicensed staff's face. When staff asked why resident #1 did that, resident #1 stated "you see no one can do me anything, even if you call the police." Staff notified the police and moved the medications to a different area.

Resident #1 went to the kitchen area and threw his plate onto the floor which broke into pieces. Resident #1 then poured urine from his urinal onto the kitchen floor and onto the unlicensed staff's leg and shoes. Later in the evening resident #1 blocked the entrance door so no one could enter or leave the facility. The police were notified. Resident #1 continued to block the door, and the unlicensed staff could not get the other resident's medications. The unlicensed staff called the police again, resident #1 moved away from the doorway once the police arrived, and the other resident's medication was eventually provided.

Resident #1 went to the refrigerator and threw tomatoes, pancakes and eggs onto the kitchen floor. Resident #1 drove over the food items with his electric wheelchair.

Resident #1 called three other residents into the attached garage and started smoking cigarettes and marijuana.

Resident #1 opened cases of incontinence products that belonged to other residents. Resident #1 threw the incontinence products on the garage floor. Resident #1 laughed at staff and

opened a case of nutritional supplements that belonged to another resident and poured the nutritional supplement onto the incontinent products.

Resident #1 went to the kitchen, got nutritional supplements and uncooked rice and poured the items on the living room floor. Resident #1 then took another urinal of urine and poured it onto the dining room table and chair. Resident #1 was sent to the hospital for an evaluation.

There were no changes to interventions for behaviors when resident #1 returned from the hospital evaluation.

Resident #1 went to the kitchen and started smoking marijuana. Staff asked resident #1 not to smoke inside the facility. Resident #1 got close to the unlicensed staff and blew marijuana smoke into the staff's face. Resident #1 stated "how do you like it."

Resident #1 was found smoking in the attached garage. Staff reminded resident #1 not to smoke inside the facility. Resident #1 refused and stated, "no one can tell me what to do."

Resident #1 blocked a unlicensed staff from the stove so that dinner could not be made for resident #1 or other residents. The unlicensed staff called an emergency mental health response team and the police. Police arrived at the facility and told the unlicensed staff resident #1 was protesting and there was nothing they could do. Takeout food was eventually ordered for the residents.

Resident #1 started smoking in the garage, when asked to move to a designated area, resident #1 refused. When the unlicensed staff closed the door to the garage from the facility, resident #1 came into the facility and started smoking in the living room.

Resident #1 took a whole cooked chicken off the counter that was cooked for all of the residents' lunch and brought it to his room. When asked why, resident #1 stated "this is what I do." Lunch had to be cooked again for all other residents. Later in the day, resident #1 went to the kitchen and poured ranch, mustard, and urine onto the kitchen floor.

Resident #1 blocked the stove and prevented staff from cooking dinner for the residents. Resident #1 stated he liked doing this because the police and mental health response team cannot do anything. Takeout food was ordered.

Resident #1 went to the kitchen and started making a smoothie. When resident #1 was done blending everything, he poured the smoothie onto the countertops, table and chairs. Then resident #1 went to his room, and returned with a spray bottle full of urine, and started to spray the cabinets, inside a closet, the doorknobs, and dining room table. Resident #1 stated, "I like doing this to give staff work to do."

Resident #1 was found spraying a substance onto a unlicensed staff's car. After a few hours, resident #1 went into the kitchen with a spray bottle full of urine and started spraying it onto the kitchen sink, a doorknob, the refrigerator, the windows, and the kitchen floor. Then resident #1 took food and a liquid substance and poured it on the floor. Resident #1 drove his electric wheelchair through everything he poured on the floor.

Resident #1 removed the knobs from the stove and locked them in his room. Resident #1 told staff no one could take them away.

Resident #1 made a smoothie and poured the smoothie onto the kitchen floor, living room floor, dining room table, down the stairwell, over the stove and countertops. Resident #1 then took a spray bottle full of urine and sprayed the doorknobs, living room chairs and dining room chairs. Resident #1 stated he will continue to give the staff work to do and no one can stop him. Later in the evening resident #1 blocked staff from using the stove to make dinner. Takeout food was ordered for all residents.

Resident #1 removed the top grates of the gas stove and stated he would like to see how staff were going to use the stove.

Video footage with audio showed a dismantled kitchen stove. The top grates and knobs of the gas stove were missing and an unlicensed staff described on audio resident #1 had removed the parts and locked the parts in his room.

Resident #1 parked his electric wheelchair in front of the stove and blocked staff from making dinner. Staff called mental health response team and ordered takeout food for the residents.

Resident #1 poured urine and ketchup into a spray bottle and started to spray the substance all over the kitchen, stove, ceiling, cabinets, living room, and dining room table. Then resident #1 took a smoothie mixture and poured it on the stove, cabinets, stairwell, kitchen and living room floor. Resident #1 then threatened to "key" an unlicensed staff's car. Later in the evening, resident #1 stuck a piece of metal into another resident's doorknob to prevent the other resident from locking his door.

Resident #1 removed the doorknob and lock from the front door of the facility. When an unlicensed staff told resident #1 to stop, resident #1 stated “you know you cannot touch me or stop me from doing anything”.

Resident #1 opened a storm door and let the storm door swing in the wind. When resident #1 was asked to close the storm door he blocked the unlicensed staff from getting into her car. Resident #1 punched the unlicensed staff in the arm.

Resident #1 took another resident's incontinent products and scattered them onto the living room floor. Then resident #1 took another resident's nutritional supplements and poured them

onto the incontinent products. Resident #1 went to his room and came out with a urinal full of urine and poured the urine onto the living room floor. Resident #1 exited the facility and poured urine and nutritional supplements onto an unlicensed staff 's car. Police were notified. Later that morning, resident #1 broke into a locked cabinet and took two medical charts that belonged to other residents. Resident #1 refused to return the medical charts.

Video footage with audio showed resident #1 sitting at a table with approximately 56 large incontinent products belonging to another resident spread out on the floor in front of him. The incontinent products covered an area that was approximately four feet by eight feet. Resident #1 smiled and waved at the camera and repeatedly filled a large tube feeding syringe with an unknown substance from kitchen pans. Resident #1 repeatedly sprayed the unknown substance into the pile of briefs. An empty box sitting in the pile appears to indicate it was a full case of briefs that resident #1 destroyed. Resident #1 stated on audio, "water never hurt nobody, right."

Law enforcement reports indicated law enforcement was contacted thirty times and had completed twelve reports regarding incidents at the facility.

Fire department reports indicated gas was shut off to the facility's cooking stove when resident #1 reported to the fire department that the stove leaked gas and was a fire hazard. Fire department reports indicated wall outlets were missing face plates, electrical components were visible, and smoke alarms were alerting low batteries. Fire department reports indicated fire personnel were called to the facility three times by resident #1 to assist resident #1 into the facility when resident #1 reported to the fire department unlicensed staff would not assist him.

Resident #1's functional assessment was provided to the facility for review before resident #1 was accepted into the facility and contained resident #1's history. Resident #1 had a criminal history, complex behavioral needs and had severely harmed coresidents at prior facilities. Resident #1's functional assessment indicated resident #1 required a behavioral support plan to prevent or reduce resident #1's potential to harm others or break the law. A functional assessment indicated resident #1's physical aggression had the potential to put others at risk. A functional assessment indicated interventions and supervision were needed by others to reduce risk of harm. The facility had not developed a behavioral support plan for resident #1.

Review of resident #1, resident #2, resident #3, resident #4, resident #5 and resident #6 medical record lacked evidence the facility implemented new interventions to maintain resident #1, resident #2, resident #3, resident #4, resident #5 and resident #6's physical and mental health or safety.

During an interview, unlicensed staff #1 stated all the residents, and some staff were fearful of resident #1. Unlicensed staff stated one staff was not coming to work because resident #1 poured urine "all over her" and "something happens almost every day". Unlicensed staff #1 stated she had assisted resident #1 and when she went to assist a second resident, resident #1

went outside and poured urine and ketchup all over her vehicle. Resident #1 smoked in his room every day and when she redirected him, he blew smoke in her face. Unlicensed staff #1 stated she did not feel safe and other residents stayed in their rooms to avoid resident #1.

During an interview, unlicensed staff #2 stated resident #1 had removed gas stove parts and unlicensed staff were unable to cook for residents. Resident #1 wanted unlicensed staff to quit their jobs and when unlicensed staff #2 didn't quit, resident #1 told unlicensed staff #2 he had his home address. Unlicensed staff #2 stated resident #1 stopped him from assisting other residents by blocking the entrance and exits with his electric wheelchair and medical supplies that belonged to other residents were destroyed by resident #1. Unlicensed staff #2's vehicle had been vandalized by resident #1.

During an interview, a licensed staff stated resident #1 removed and hid fire extinguishers from the facility and smoked in his room. Licensed staff stated other residents mimicked resident #1's behaviors when resident #1 told other residents if they did not cooperate with him, he would withhold their cigarettes from them. Food could not be kept on the main level in a refrigerator or cabinets because resident #1 removed the food and ran it over with his electric wheelchair. Licensed staff stated other residents were redirected and removed from the main area when resident #1 was angry and poured or smeared urine, blended food substances and feces around the kitchen and appliances. Other residents were redirected to their rooms to prevent falls and injuries when resident #1 covered surfaces with food, liquids and unsanitary substances. Licensed staff stated staff were unable to use a stove to cook for residents because resident #1 had removed parts and the fire department disconnected the gas from the stove. Licensed staff stated resident #1 had struck her twice and prevented staff from providing cares for other residents when he used his electric wheelchair to block staff in rooms for up to an hour. Licensed staff stated resident #1 was not a good fit with the facility.

During an interview, a mental health case manager indicated resident #1 had stopped participating in mental health treatments since he was admitted to the facility.

During an interview, a case manager stated resident #1 completed a virtual interview and tour with facility management before moving to the facility. Resident #1 had a history of acting out if resident #1 did not feel heard and resident #1's placement at the facility was not working out. A case manager stated she learned during a meeting for resident #1 that facility leadership had not reviewed information that explained resident #1's needs before resident #1 was accepted for admission. A case manager stated resident #1 had a history of interactions with law enforcement and behaviors, however, smearing feces and pouring/spraying urine on others was new.

During an interview, resident #1 stated the facility's kitchen appliances were not operable because the fire department disconnected the stove from the gas. Resident #1 stated unlicensed staff "don't understand how to cook" so he used a hot plate and air fryer in his room to cook his food. Resident #1 stated the plug-in used for the hot plate was a "fire hazard"

because the plug lacked a face plate and he was aware of “about 6 fire violations”. Resident #1 stated residents were supposed to smoke outside, however, “everybody smokes in the house”. Resident #1 stated law enforcement is called “at least six times a month”. Resident #1 stated when he poured or sprayed substances around the facility “they would just leave it there” and he would not participate in the cleanup. Resident #1 stated he went to a community store a few times a week to purchase items used to spray on staff vehicles.

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: Resident #1 yes. Due to safety concerns others were not interviewed.
Family/Responsible Party interviewed: No.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility reached out to law enforcement and other outside agencies for assistance.

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
Hennepin County Attorney
Bloomington City Attorney
Bloomington Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28558	A. BUILDING: _____ B. WING _____	C 04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JAMES INC	10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431

(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: #HL285582700M/#HL285589840C and #HL285582881M/HL285581355C On April 7, 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 six residents receiving services under the provider's Assisted Living license. No correction orders are issued for #HL285582700M/ #HL285589840C. The following correction orders are issued for #HL285582881M/HL285581355C, tag identification 2360.	0 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28558	A. BUILDING: _____ B. WING _____	C 04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JAMES INC	10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431

(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
02360	Continued From page 1	02360		
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 observation, interviews, and document review, the facility failed to ensure six of six residents reviewed (R1, R2, R3, R4, R5, R6) were free from maltreatment. Findings include: On April 7, 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		