STATE LICENSING COMPLIANCE REPORT

Report: HL331231562C

Date Concluded: June 17, 2026

Name, Address, and County of Facility Investigated:
Kubra Home Care Inc
2437 15th Avenue South
Minneapolis, MN 55404
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if there are any, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

Or call 651-201-4201 to be provided with a copy via mail or email.

If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33123	A. BUILDING: _____ B. WING _____	C 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUBRA HOME CARE INC	2437 15TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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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: #HL331231562C On June 9, 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 3 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL331231562C, tag identification 0450, 1040, 1130, 2290, 2310, and 2370.	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.	
0 450 SS=F	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall:	0 450		

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0 450	Continued From page 1 (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to utilize a person-centered planning and service delivery process when the license failed to ensure one of one residents (R2) had necessary housekeeping and laundry services provided and had his room kept in good repair. In addition, the licensee failed to utilize person-centered planning related to food. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2's diagnoses included schizophrenia.	0 450		

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0 450	Continued From page 2 R2's service plan dated May 19, 2025, indicated the facility changed linens once per week and would do daily housekeeping if needed. On June 9, 2026, at 10:15 a.m., the investigator observed R2's bedroom. A window by R2's bed was open and no screen was in place. Several parts of the blinds were bent and appeared broken. There were no sheets on R2's bed. R2's mattress was on the floor, with no bed frame. Various items of clothing were scattered on the floor. Part of the flooring was damaged. On June 24, 2026, at 1:40 p.m., clinical nurse supervisor (CNS)-C was asked if she had noticed R2's missing sheets and messy room. CNS-C stated her role only included medications and admissions and on call for any health problems so if anything happened in the house, she was not responsible. FOOD On June 9, 2026, at 9:45 a.m., the investigator observed the kitchen in the facility and observed there was not much food available. A menu was posted in the kitchen and the investigator asked the staff member where the food was to prepare the day's planned menu. The menu for Tuesday included pancakes and eggs for breakfast, granola bar for morning snack, chicken rice bowl for lunch, an orange for afternoon snack, and beef burger with fries for supper. The staff member stated the facility did not prepare meals and they would take the residents grocery shopping so they could prepare their own food. On June 24, 2026, at 1:40 p.m., CNS-C stated she didn't notice that there wasn't much food in the house.	0 450		

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0 450	Continued From page 3 TIME PERIOD FOR CORRECTION: Seven (7) days	0 450		
01040 SS=D	144G.52 Subd. 7 Notice of contract termination required (a) A facility terminating a contract must issue a written notice of termination according to this section. The facility must also send a copy of the termination notice to the Office of Ombudsman for Long-Term Care and, for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5. (b) A facility terminating a contract under subdivision 3 or 4 must provide a written termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative. (c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal representative, and designated representative. (d) If a resident moves out of a facility or cancels services received from the facility, nothing in this section prohibits a facility from enforcing against the resident any notice periods with which the resident must comply under the assisted living contract. This MN Requirement is not met as evidenced by:	01040		

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01040	Continued From page 4 Based on interview and record review, the licensee failed to issue a written notice for a termination of contract at least 30 days ahead of the termination, or at least 15 days ahead of an expedited termination for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), 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 diagnoses included substance use psychosis, schizophrenia, and bipolar disorder. R1's assessment dated February 26, 2026, indicated the resident had prior unsuccessful placements due to behavioral and mental health instability. R1's assessment did not include any interventions related to the resident smoking in the facility. The assessment did not include interventions related to R1's behaviors. Notes on the assessment indicated R1's behaviors were getting worse and they were looking for a new group home [assisted living] to move to. R1's service plan dated November 10, 2025, indicated the resident received behavior/orientation services and had a mental health care plan. A mental health care plan was requested, but not provided. R1's record lacked evidence of a termination	01040		

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01040	Continued From page 5 notice. R1 received a written warning on December 8, 2025, for using illegal substances "specifically marijuana/weed" inside his room. The written warning indicated effective immediately, if he was found using "weed" or any illegal substances again anywhere on facility property, he would face immediate eviction from the facility for the second warning. R1 received a final warning on December 30, 2025, for a violation of the house rules. It noted on November 26, 2025, R1 got a written warning for "having illegal substances (marijuana) in your room." On December 24, 2025, staff were noted to have searched the resident's room and found alcohol bottles. The warning indicated alcohol was "not allowed in the group home [assisted living] according to rules." R1 was noted to be smoking in his room on December 29, 2025. The final warning signed on January 6, 2026, indicated "if this continues we have to issue a 30 days eviction notice." R1's record contained an agreement of 30 day eviction extension notice signed on February 10, 2026. It was noted the facility was extending his 30 day eviction at the request of his family and case manager. The extension would go through February 28th and R1 and his father "have agreed to actively seek an alternative group home or other housing placement for him following the end of the extension period." R1 was noted to agree to "comply with all house rules" and failure to follow house rules or any behavior that placed residents or staff at risk would result in immediate revocation of the extension and R1 would "be required to secure alternative housing as soon as possible."	01040		

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01040	Continued From page 6 R1 was discharged from the facility on March 13, 2026. The facility that R1 was supposed to admit to did not accept him for admission, resulting in R1 being homeless until accepted by a new facility about a month later. Notes entered by R1's county case manager indicated on March 6, 2026, the facility emailed the case manager sharing that R1 had agreed to move to a new home and that the county case manager would need to reach out regarding the move and R1 could only stay at the facility until March 10th. The case manager identified that the facility R1 was planning to discharge to was unable to accept R1 as a resident due to payer restrictions. On March 16, 2026, the case manager documented she got a call from R1's dad informing her that R1 had been discharged without proper living arrangements set up. R1's dad wrote that licensed assisted living director (LALD)-A had "coordinated moving him to a new home at [address] saying that a car from there would pick him up at 11 a.m. Friday March 13. He had indeed picked up and delivered to the new address, where they informed him he could not stay..." The case manager's reply to R1's dad indicated she had communicated with LALD-A and the other facility that the home was not approved to move in due to DHS policy, which she was in the process of getting an exception approval from DHS. The case manager wrote R1's discharge was "done without me being present or aware until after [R1] was picked up." R1 called the case manager and reported that he didn't have anywhere to go right now and that he did not have money for a hotel. On June 8, 2026, at 11:40 a.m., R1's dad stated the facility had been looking to discharge R1 and	01040		

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01040	Continued From page 7 one day he got a message from LALD-A saying that R1 had been discharged and he didn't know anything about it. R1's dad stated the facility R1 was supposed to admit to would not accept him and he had tried calling LALD-A to see if R1 could return to the facility but she did not answer or return his phone call. R1's dad stated it was a "shock" to find out his son was out on the street when it was 20 below and he had to make arrangements to find places for R1 to stay until a new facility could be found. R1's dad stated he stayed in hotels until he was kicked out and stayed on various friend's couches for about a month. On June 10, 2026, at 11:35 a.m., R1 stated the facility had kicked him out for smoking in the house and he was homeless and slept outside until a new facility was found for him. On June 22, 2026, at 9:40 a.m., LALD-A stated R1 had found a new facility to move to and she only heard later from R1's case manager that he was not accepted at the new facility. On June 22, 2026, at 2:30 p.m., R1's case manager, CM-B, stated the facility had no real termination process and she had mentioned to them if they wanted to terminate R1's assisted living contract, they would have to do a five day notice and do a final termination letter and do a pre-termination meeting that the resident would have the right to appeal. On June 24, 2026, at 1:40 p.m., clinical nurse supervisor (CNS)-C stated the director was involved with R1's discharge and that R1 had found a place to discharge to so he went there. No further information provided.	01040		

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01040	Continued From page 8 TIME PERIOD TO CORRECT: Twenty-one (21) days.	01040		
01130 SS=G	144G.55 Subd. 2 Safe location A safe location is not a private home where the occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel. A facility may not terminate a resident's housing or services if the resident will, as the result of the termination, become homeless, as that term is defined in section 116L.361, subdivision 5, or if an adequate and safe discharge location or adequate and needed service provider has not been identified. This subdivision does not preclude a resident from declining to move to the location the facility identifies. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one resident (R1) was discharged to an adequate and safe location and needed service provider. R1 was discharged to a facility that could not accept him due to payment restrictions. R1 was not able to return to the facility and was homeless for about a month until other placement could be found. This practice resulted in a level three violation (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), 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).	01130		

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01130	Continued From page 9 Findings Include: R1's diagnoses included substance use psychosis, schizophrenia, and bipolar disorder. R1's assessment dated February 26, 2026, indicated the resident had prior unsuccessful placements due to behavioral and mental health instability. R1's assessment did not include any interventions related to the resident smoking in the facility. The assessment did not include interventions related to R1's behaviors. Notes on the assessment indicated R1's behaviors were getting worse and they were looking for a new group home [assisted living] to move to. R1's service plan dated November 10, 2025, indicated the resident received behavior/orientation services and had a mental health care plan. A mental health care plan was requested, but not provided. R1's record lacked evidence of a termination notice. R1 was discharged from the facility on March 13, 2026. The facility that R1 was supposed to admit to did not accept him for admission, resulting in R1 being homeless until accepted by a new facility about a month later. Notes entered by R1's county case manager indicated on March 6, 2026, the facility emailed the case manager sharing that R1 had agreed to move to a new home and that the county case manager would need to reach out regarding the move and R1 could only stay at the facility until March 10th. The case manager identified that the facility R1 was planning to discharge to was	01130		

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01130	Continued From page 10 unable to accept R1 as a resident due to payer restrictions. On March 16, 2026, the case manager documented she got a call from R1's dad informing her that R1 had been discharged without proper living arrangements set up. R1's dad wrote that licensed assisted living director (LALD)-A had "coordinated moving him to a new home at [address] saying that a car from there would pick him up at 11 a.m. Friday March 13. He had indeed picked up and delivered to the new address, where they informed him he could not stay..." The case manager's reply to R1's dad indicated she had communicated with LALD-A and the other facility that the home was not approved to move in due to DHS policy, which she was in the process of getting an exception approval from DHS. The case manager wrote R1's discharge was "done without me being present or aware until after [R1] was picked up." R1 called the case manager and reported that he didn't have anywhere to go right now and that he did not have money for a hotel. On June 8, 2026, at 11:40 a.m., R1's dad stated the facility had been looking to discharge R1 and one day he got a message from LALD-A saying that R1 had been discharged and he didn't know anything about it. R1's dad stated the facility R1 was supposed to admit to would not accept him and he had tried calling LALD-A to see if R1 could return to the facility but she did not answer or return his phone call. R1's dad stated it was a "shock" to find out his son was out on the street when it was 20 below and he had to make arrangements to find places for R1 to stay until a new facility could be found. R1's dad stated he stayed in hotels until he was kicked out and stayed on various friend's couches for about a month.	01130		

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01130	Continued From page 11 On June 10, 2026, at 11:35 a.m., R1 stated the facility had kicked him out for smoking in the house and he was homeless and slept outside until a new facility was found for him. On June 22, 2026, at 9:40 a.m., LALD-A stated R1 had found a new facility to move to and she only heard later from R1's case manager that he was not accepted at the new facility. On June 22, 2026, at 2:30 p.m., R1's case manager, CM-B, stated she had been communicating a discharge plan with the facility and when she was doing approvals, it came back that R1 would not be eligible to live at the new facility and she updated LALD-A of that. CM-B stated she had told the facility that R1 could not move in to the new facility and that it was denied and they'd have to find a different home and then she later got an email saying that as of today, he has moved. CM-B stated the facility had no real termination process and she had mentioned to them if they wanted to terminate R1's assisted living contract, they would have to do a five day notice and do a final termination letter and do a pre-termination meeting that the resident would have the right to appeal. Minnesota (MN) Statute 144G.55, Subd. 2, Safe Location. A safe location is not a private home where the occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel. A facility may not terminate a resident's housing or services if the resident will, as a result of the termination, become homeless, as that term is defined in section 116L.361, Subd. 5, or if an adequate and unsafe discharge location or adequate and needed service provider has not been identified.	01130		

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01130	Continued From page 12 No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	01130		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee included language within the residency agreement contract and in house rules which limited the rights of all residents residing within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included substance use psychosis, schizophrenia, and bipolar disorder. R1 received a written warning on December 8, 2025, for using illegal substances "specifically marijuana/weed" inside his room. The written	02290		

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	33123	A. BUILDING: _____ B. WING _____	C 06/09/2026

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02290	Continued From page 13 warning indicated effective immediately, if he was found using "weed" or any illegal substances again anywhere on facility property, he would face immediate eviction from the facility for the second warning. R1 received a final warning on December 30, 2025, for a violation of the house rules. It noted on November 26, 2025, R1 got a written warning for "having illegal substances (marijuana) in your room." On December 24, 2025, staff were noted to have searched the resident's room and found alcohol bottles. The warning indicated alcohol was "not allowed in the group home [assisted living] according to rules." R1 was noted to be smoking in his room on December 29, 2025. The final warning signed on January 6, 2026, indicated "if this continues we have to issue a 30 days eviction notice." R1's record contained an agreement of 30 day eviction extension notice signed on February 10, 2026. It was noted the facility was extending his 30 day eviction at the request of his family and case manager. The extension would go through February 28th and R1 and his father "have agreed to actively seek an alternative group home or other housing placement for him following the end of the extension period." R1 was noted to agree to "comply with all house rules" and failure to follow house rules or any behavior that placed residents or staff at risk would result in immediate revocation of the extension and R1 would "be required to secure alternative housing as soon as possible." The licensee's Client [resident] Handbook included the following rules which limited resident rights: -Residents may have visitor in common area	02290		

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02290	Continued From page 14 -Last call for smoking is 11:00 PM unless otherwise approved by staff. In regards to alcohol, marijuana, and drugs, the licensee had the following rules which limited resident rights: To maintain a safe and healthy environment, the following are strictly prohibited: -Possession, use, sale, or distribution of alcohol. -Possession, use, sale, or distribution of marijuana. -Being under the influence of alcohol or illegal substances while on the property. -Sharing prohibited substances with other residents or visitors. Any violation of this policy may result in immediate disciplinary action, including termination of residency. The handbook indicated residents are expected to follow the policies outlined in the handbook and cooperate with staff in maintaining a positive living environment. Failure to follow the rules would result in review of services, support planning, and residency status as appropriate. On June 22, 2026, at 9:40 a.m., LALD-A stated she was not aware assisted living facilities could not have house rules. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted	02310		

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02310	Continued From page 15 living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement a service plan based on R1's needs and appropriate R1's known history of smoking in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), 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 diagnoses included substance use psychosis, schizophrenia, and bipolar disorder. R1's service plan dated November 10, 2025, indicated the resident received behavior/orientation services and had a mental health care plan. A mental health care plan was requested, but not provided. R1's assessment dated February 26, 2026, indicated the resident had prior unsuccessful placements due to behavioral and mental health instability. R1's assessment did not include any interventions related to the resident smoking in the facility. The assessment did not include interventions related to R1's behaviors. Notes on	02310		

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02310	Continued From page 16 the assessment indicated R1's behaviors were getting worse and they were looking for a new group home [assisted living] to move to. The assessment indicated R1 was at risk for emotional or psychological distress due to personal losses as the resident had behavioral and mental health instability. R1's assessment indicated the resident also had a past history of smoking issues and concerns and had an incident with smoking at the residence. Interventions identified included smoking cessation and education materials. R1's progress notes from February 1, 2026, through March 13, 2026 were reviewed. The notes identified at least 21 occasions were R1 was noted to be smoking in his room, sometimes setting off the fire alarm. R1 was noted to refuse staff interventions of asking him to not smoke in the house. The notes lacked evidence the nurse was updated on the ongoing behaviors of smoking in the facility. -February 5, 2026, R1 "appeared depressed today and displayed over actively behavior" including smoking excessively. R1 was asked to not smoke inside but did not comply. R1 spent most of the day smoking inside and "told him every time" but R1 didn't listen. -February 8, 2026, R1 was smoking in his room. -February 9, 2026, R1 "appeared depressed today, he was smoking excessively." R1 did not listen to staff instructions to stop smoking inside. -February 10, 2026, R1 was smoking in the facility and "looked absentminded." -February 20, 2026, R1 was "smoking	02310		

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02310	Continued From page 17 excessively" and told by staff to not smoke indoors however he did not comply with staff instructions and continued smoking inside. -February 21, 2026, R1 was smoking in the facility. -February 22, 2026, R1 was smoking in the facility. -February 23, 2026, R1 "appeared depressed and upset during the shift." Staff attempted to redirect but "he responded by insulting staff." R1 was smoking in the facility. -February 24, 2026, R1 was smoking in the facility and did not follow staff instructions to not smoke in the facility. Later that day, he was smoking marijuana in his room and set off the fire alarms. -February 25, 2026, R1 was smoking in the facility and "was not listening to staff redirection and required multiple reminders regarding house rules." -March 1, 2026, R1 was yelling and shouting in his room and talking a lot and smoking "something" inside the facility. -March 2, 2026, R1 was smoking in the facility. R1 was also noted to be yelling and screaming for several hours until he was gradually de-escalated. -March 3, 2026, R1 was yelling "too much" and was insulting the neighbors. R1 was smoking in the facility. -March 4, 2026, R1 was "yelling too much" and	02310		

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02310	Continued From page 18 was insulting the neighbors. R1 was smoking in the facility. During the overnight hours, he "started shouting insulting staff he's open the window (sic) and insulting neighbor also kicking the door and staff calling 911 at 2 am." Police came and talked to R1 and was later shouting loudly at the TV. -March 5, 2026, R1 was yelling, screaming, and shouting and was de-escalated. Later that evening, he was smoking marijuana in the facility. -March 6, 2026, R1 was observed talking to himself and walking back and forth. Later that evening, R1 set off the smoke alarm while smoking in the facility. -March 7, 2026, R1 was "home screaming and yelling." -March 8, 2026, R1 was "home screaming and yelling" and also smoking marijuana inside. -March 9, 2026, R1 was smoking in the facility and "appeared upset at times and was not listening to staff directions." -March 10, 2026, R1 was smoking in the facility and walking around, not respecting other residents. -March 11, 2026, R1 woke up screaming and yelling and "appeared restless." Staff attempted to redirect him. R1 was also smoking in the facility. -March 12, 2026, R1 was smoking marijuana in the facility and was "so bad smelling [R1] does not hear staff and always smoke indoors."	02310		

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02310	Continued From page 19 On June 24, 2026, at 1:40 p.m., clinical nurse supervisor (CNS)-C stated she was only at the facility a few hours a week and most of the time R1 wasn't there when she was there and it was hard to catch him. CNS-C stated she never observed R1 smoking so that was why the assessment did not include his noncompliance with smoking in the facility. CNS-C stated she wouldn't be able to assess R1's smoking if she didn't see it. CNS-C stated R1 had behaviors and staff would call 911 and she wasn't able to say if that was an appropriate intervention because she was not there. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02370 SS=F	144G.91 Subd. 9 Right to come and go freely Residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one resident (R2) had the right to enter and leave the facility as they chose. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	02370		

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02370	Continued From page 20 are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2's diagnoses included schizophrenia. R2's contract signed May 19, 2025, indicated residents were not assigned a key for the entrance to the doors of the house but the facility was staffed 24 hours per day. On June 9, 2026, at 9:30 a.m., the investigator knocked on the door of the facility with no answer. Both doors were locked. A phone call to a publicly listed phone number to the facility was not answered. On June 9, 2026, at 9:35 a.m., R2 approached the facility and was unable to open the doors. R2 went around to the back of the facility, opened a window, and entered the facility through the window. On June 9, 2026, at 9:40 a.m., the investigator went back to the front of the facility and attempted the door again and located a door bell approximately a foot above eye level. A facility staff member opened the door a short while later. On June 9, 2026, at 9:45 a.m., the facility staff member confirmed the doors were locked. The staff member stated R2 had never used the window to enter the facility before. On June 22, 2026, at 9:40 a.m., LALD-A stated there was a keypad residents could use to enter a code to access the facility and she was not sure why R2 didn't remember it. LALD-A stated R2 had	02370		

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02370	Continued From page 21 never entered the facility through the window before. LALD-A stated the facility was locked at all times for safety reasons. The Minnesota Bill of Rights for Assisted Living Residents dated August 2022, under the Right to come and go freely, indicated residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	02370		