Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL334251820M
Compliance #: HL334256900C

Date Concluded: April 21, 2026

Name, Address, and County of Licensee Investigated:
Restful Home LLC
1000 Reaney Avenue
St. Paul, MN 55106
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, 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: It is alleged the facility neglected the resident when it failed to supervise the resident who left the facility and was found deceased.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. While it was true the resident left the facility and was later found deceased, the facility could not prevent her from leaving. The resident did not share with the facility staff where she was going nor when she would return.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the case worker. The investigation included review of the resident record, death record, medical provider visit notes, facility incident reports, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed staff and resident routine activity during a recent visit to the facility.

The resident resided in an assisted living facility with diagnoses of schizophrenia. The resident's service plan included assistance with medication management, reminders for personal care, meals and housekeeping. The resident's risk assessment indicated the resident had a history of wandering off from the facility but typically returned within several hours. Staff were to discourage her from leaving but when redirection led to the resident becoming aggressive and necessitated a call to law enforcement. Staff members were directed to monitor the resident for signs of agitation, aggression, and signs of suicidal ideation.

A concern arose when the resident left the facility early one morning and did not return. The facility received word the following day that the resident was found deceased.

Progress notes indicated the resident left the facility that morning without explanation of why or where she was going. The caregiver called the manager to report the resident left. The manager filed a missing person's report when the resident had been gone 24 hours.

A medical provider note indicated the resident had a recent history of violence and had been taken into custody twice in the months prior for assaults. The resident had been medically evaluated each time, and her medication regimen was adjusted.

During an interview, a caregiver stated the resident left early that morning without explanation and just walked out the door. He stated he did not follow out or confront the resident but called the manager to let him know the resident had left the facility.

During interview, the case manager stated the resident had recently assaulted a facility caregiver and a dental hygienist at a recent dental appointment. The care team met and discussed the facility's ability to take the resident back. They discussed an action plan to include referrals to ACT (Assertive Community Treatment), which could provide support as an alternative to sending the resident to the hospital during a mental health episode.

During an interview, the facility manager stated the facility could not keep the resident from leaving and had left the facility before and returned. The resident had once assaulted staff when asked questions about where she was going. The manager stated a missing person's report had been filed once, but police could not initiate a search until 24 hours had passed. The manager clarified the facility was not set up to provide one-to-one continuous observation care but one-to-one visits with the resident were completed as check-ins to see how she was doing when there were increased behavior concerns. The resident's care team met and discussed additional ways to support the resident.

A review of the Information provided by interview conflicted with the facility Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) which is marked yes and indicated the facility has one-to-one staffing available.

A police investigation report indicated video footage captured the resident's activity near the downtown area. The resident's death certificate indicated the resident died as a result of a fall with traumatic injuries.

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: No action taken.

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
	33425	A. BUILDING: _____ B. WING _____	C 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTFUL HOME LLC	1000 REANEY AVENUE SAINT PAUL, MN 55106

(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: #HL334256900C/#HL334251820M. On March 5, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were eight (8) residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL334256900C/#HL334251820M, tag identification 0430.	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.	
0 430 SS=F	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) was accurate for one of one resident (R1) with records reviewed. This had the potential to affect all eight residents receiving assisted living services. 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	0 430		

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0 430	Continued From page 2 portion or all of the residents). The findings include: R1's UDALSA dated June 10, 2021, and signed by R1 on November 14, 2024, indicated "one-to-one staffing available." On March 5, 2026, at 12:15 p.m., the licensed assisted living director (LALD)-A stated that staff provided 1:1 with R1. LALD-A clarified that this was time spent in a therapeutic manner and not one-to-one staffing supervision. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 430		