Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL354837682M
Compliance #: HL354837725C

Date Concluded: April 6, 2026

Name, Address, and County of Licensee Investigated:
Paradise Care Homes LLC
4031 2nd Avenue South
Minneapolis, MN 55409
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Substantiated, facility and individual 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 a resident when they failed to provide supervision. As a result, the resident died from street drug overdose.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility, AP #1 (a manager), and AP #2 (a nurse) were responsible for the maltreatment. The facilities systemic failures contributed to the lack of resident oversight. AP #1 acted outside her scope of practice and developed care planning interventions. AP #2 failed to perform duties in a manner consistent with nursing practice by implementing required safety interventions and directive of supervision to unlicensed personnel. AP #2 deferred her responsibilities to AP #1. Although the unlicensed personnel failed to complete safety checks, this was a common practice at the facility known by AP #1. The unlicensed personnel had no access to resident care plan records because AP #1 and AP #2 kept the records at a different location (not in the facility).

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the pharmacy. The investigation included review of the resident records, death record, facility internal investigation, facility incident reports, personnel files, pharmacy records, law enforcement report, and related facility policy and procedures. Also, the investigator toured the facility and observed the facilities process for medication management, staffing, and documentation systems.

The resident resided in an assisted living facility. The resident's diagnoses included Schizophrenia, hallucinations, suicidal ideations, and anxiety. The resident had a history of substance abuse (drug use). The resident's service plan included assistance with medications. The service plan indicated the resident required daily safety checks and mental health management "as needed" (PRN).

The resident's nursing assessment, completed by AP #2, indicated the resident had mental illness, developmental disorder, and substance abuse/chemical abuse. The resident was prescribed psychotropic medications. The assessment indicated the resident had suicide ideation, was withdrawn, self-isolated and had poor decision-making ability. The assessment did not indicate the resident was physically or verbally aggressive or had any negative behavioral concerns. The assessment failed to contain person centered, individualized interventions for staff to manage self-harm vulnerabilities.

AP #1 completed a county support plan and submitted it to the county for payment for services the facility would provide to the resident. The support plan indicated the resident had a history of suicide attempts, and was at risk for self-neglect, substance use, and hallucinations. The resident was unable to control himself and required staff to redirect him from these behaviors. AP #1 indicated the facility would develop a behavior care plan to manage these behaviors.

The resident's record lacked a behavior care plan.

The resident individual abuse prevention plan (IAPP) identified the resident was at risk to be abused by others and at risk for self-abuse. The IAPP failed to included individualized interventions to prevent self-harm and abuse from others. The IAPP indicated staff would "monitor" the resident and report changes to the nurse. There was no specific direction on what staff was monitoring nor the frequency.

The resident's medication administration records indicated the resident received a daily anti-anxiety medication and two different anti-psychotic medications for schizophrenia administered once daily and the other twice daily.

The facility failed to have a medication administration record for the month the resident died and therefore, failed to have documentation of the resident's medication administration for 23 days.

Eight days before the resident's death, AP #1 submitted an updated county support plan to the county. The support plan indicated the resident had additional behaviors such as hitting and kicking. The support plan indicated the resident required the facility to manage his anxiety, agitation, and self-injurious behavior. The facility would provide redirection, calm environment, and immediately report any changes to the nurse. Other interventions listed on the support plan indicated the staff would offer the resident coping mechanisms and redirection.

The resident's record lacked an updated nursing assessment by AP #2 that supported the additional behaviors identified by AP #1 in the support plan. Additionally, the interventions AP #1 identified in the plan were not implemented in the resident's services or IAPP for unlicensed personnel (ULP) to review and implement.

Progress notes lacked any documentation from ULPs regarding the resident around the time of the incident. Three days prior to the incident, AP #1 documented the resident wanted to stay out of the facility overnight with his family but there was no further detail about when he left or returned. There was no further documentation until AP #1 documented the resident's death.

The resident's "overnight rounds sheet" indicated the facility ULP documented observation of the resident every two hours starting at 9:00 p.m. through 7:00 a.m. Review of the previous two weeks indicated the resident was out of the facility overnight four total days. The resident was out overnight, three consecutive days prior to the night before the resident died. The record indicated staff last observed the resident at 7:00 a.m.

An incident report, completed by AP #1, indicated ULP #1 went to the resident's room to give him morning medications. The report indicated the resident did not respond to the knock on his door, so ULP #1 opened the door and found the resident lying on the floor. ULP #1 called emergency services (911) who responded and found the resident deceased. The report indicated law enforcement found drugs and paraphernalia in the resident's room. The facility's incident report lacked further information regarding what events occurred prior to the resident's death.

Law enforcement records indicated they spoke to ULP #1 at the time of the incident. ULP #1 told them ULP #2 checked on the resident late in the night and found him lying on his bedroom floor but breathing. ULP #1 told law enforcement he had not checked on the resident during his shift and discovered him unresponsive when he attempted to give him his morning medications. Additional law enforcement records indicated the resident was not at the facility the evening prior to his death, but it was unclear when he returned. Law enforcement records indicated they found drugs on the resident's bed, floor, and nightstand in addition to drug paraphernalia.

The resident's death record indicated the resident died from cocaine, ethanol, ketamine, fentanyl, and methamphetamine (combination of street drugs).

After the resident's death, ULP continued to document on the next months MAR for 21 days they "administered" medications to him.

During an interview, AP #1 said the resident lived at a skilled nursing facility prior to his admission. AP #1 said she accepted him for admission into the facility and believed the facility could meet his needs. AP #1 said the resident left the facility sometime early in the day but came back that evening. (The times were unknown because the facility had no documentation system to monitor this.) AP #1 said ULP #2 told her he saw the resident return to the facility later in the evening. AP #1 said ULP #1 told her he did not check on the resident during the night because he was sleeping. AP #1 said that was not unusual because residents do not like staff to wake them up at night. AP #1 then said ULP #1 should have checked him at the beginning of his shift and periodically during the night. AP #1 said facility staff members never saw the resident use any drugs. AP #1 said ULPs received verbal instruction to "monitor" the resident for suicidal thoughts and drug use, however they did not document their actions.

During an interview, AP #2 said she was the only nurse for the facility. AP #2 said she knew the resident admitted from a skilled nursing facility, but she did not have much information about him and AP #1 chose to admit him. AP #2 said it was her responsibility to complete nursing assessments including an IAPP to identify the resident's vulnerabilities. AP #2 said the resident had no behavior problems. AP #2 said there was a paper form for ULPs to sign when they completed safety checks, however she had not seen that paper form so she could not comment further about it. AP #2 said the facility kept the resident's records (including IAPP, and nursing assessment) at an office, not located at the facility. When asked how ULP's would know the resident's diagnoses, medical history, or interventions if they kept resident records elsewhere, AP #2 said the facility trained the ULPs when they hired them. When asked about what actions ULPs were to do to manage the resident's substance abuse, AP #2 said they were supposed to call her if anything was abnormal. AP #2 said staff did not monitor the resident every day for substance abuse because the county was not paying them to manage it, but she instructed the ULPs to monitor for the resident for drug use. AP #2 said she felt "person centered individualized interventions" (actions to reduce risk of injury) would not have prevented this incident from occurring.

During an interview, ULP #1 said when he arrived for work late in the evening, ULP #2 told him the resident was upstairs sleeping. ULP #1 said the resident had been gone from the facility two weeks prior to this night. ULP #1 said he did not check on him during the night because the resident did not want staff to wake him. ULP #1 said he was unaware the resident had a history of using drugs and he did not receive instructions on how to "monitor" him. ULP #1 said he did not know if resident records were in the facility.

During an interview, ULP #2 said the resident was not at the facility when he arrived in the afternoon for the start of his working shift. He returned about an hour later but left again. ULP #2 said the resident returned late in the evening and nothing about his behavior seemed

abnormal. ULP #2 said the resident went to his room to sleep. ULP #2 said he did not know the resident had a history of drug use.

During a follow up interview, AP #2 said AP #1 completed the county support plan and submitted it to the county for payment. AP #2 said the county would then approve the support plan and provide payment. AP #2 said she did not put information on the support plan. AP #2 said she was unsure if she had the completed plan when she assessed the resident. AP #2 said she was aware the resident had a history of substance abuse, but the resident told her he was "clean" for about a year. AP #2 said she told staff to update her if there were any changes in his behavior. When asked about the resident's aggressive behaviors as indicated on the updated support plan (submitted prior to his death), AP #2 said the resident exhibited none of those behaviors.

Multiple investigative interviews indicated the resident did not have aggressive behaviors.

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: No. Deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes. AP #1 and AP #2.

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

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
Hennepin County Attorney
Minneapolis City Attorney
Minneapolis Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35483	A. BUILDING: _____ B. WING _____	C 02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADISE CARE HOMES LLC	4031 2ND AVENUE SOUTH MINNEAPOLIS, MN 55409

(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: HL354837725C/HL354837682M On February 2, 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 two residents receiving services under the provider's Assisted Living license. The following correction orders are issued for HL354837725C/HL354837682M, tag identification 110, 470, 630, 730, 1760, 2360.	0 000		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the	0 110		

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0 110	Continued From page 1 director of record with the board. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a licensed assisted living director (LALD) precepted the licensee's licensed assisted living director (LALD)-A who had a residency permit licensure. This had the potential to affect all residents and staff. 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: Minnesota Department of Health (MDH) issued Assisted Living licensure to the licensee effective October 1, 2025, through September 30, 2026. The licensure included capacity for six residents. On February 2, 2026, at 8:11 a.m., the surveyor arrived at the licensee where two residents currently resided. On February 2, 2026, at 8:22 a.m., licensed assisted living director (LALD)-A introduced herself to the surveyor as the licensee's LALD. On February 4, 2026, at 9:03 a.m., LALD-A said she was the manager for the licensee. LALD-A	0 110		

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0 110	Continued From page 2 said she was the director in training. When asked who the licensee's LALD was, she then said she was the LALD, but had not taken her tests yet. When asked if she was the licensee's only LALD, she said she was the licensee's only LALD. LALD -A said the licensee owned two other locations, and she was the LALD for both locations. LALD-A said she started working as the LALD in August 2025. On February 4, 2026, at 11:02 a.m., Minnesota Board of Executives for Long Term Services and Supports (BELTSS) license verification search indicated LALD-A had a residency permit licensure effective date February 14, 2025, expiration date February 13, 2026. The BELTSS web site indicated the last director of record was registered nurse (RN)-B starting June 1, 2022, and ended July 1, 2023. The BELTSS website indicated qualifications to receive a temporary residency permit included establishing a mentor relationship with a LALD or a Licensed Health Service Executive (LHSE) for the duration of the permit issued. On February 11, 2026, at 9:28 a.m., during a follow up interview, LALD-A again acknowledged she was the LALD, but when asked if she had a LALD mentor, she said registered nurse (RN)-B was her LALD mentor. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA), no date, indicated an assisted living director would be on site "full time". Time Period for Correction: Two (2) days	0 110		

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0 470	Continued From page 3	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and observation, the licensee failed to provide staff members who could sufficiently communicate with the resident population at the licensee. This deficient practice had the potential to affect all residents, staff and visitors.	0 470		

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0 470	Continued From page 4 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: On February 2, 2026, at 8:11 a.m., the surveyor arrived at the licensee. A staff member opened the door, but would not allow the surveyor to enter. This staff member was later identified as unlicensed personnel (ULP)-F. ULP-F was the only caregiver at the licensee at the time of the surveyor arrival. ULP-F, then called licensed assisted living director (LALD)-A who then called the surveyor and allowed her to enter. Upon enter, ULP-F appeared to have difficulty communicating with the surveyor and required more time, and repetitive questions. On February 4, 2026, at 3:03 p.m., family member (FM)-C said they went to the licensee frequently. FM-C said they arrived at the licensee, and an unknown staff member would not allow her to enter and then was on the phone talking in a different language. FM-C could not understand what the staff member was saying. On February 3, 2026, at 1:21 p.m., the surveyor called ULP-E. The surveyor had difficulty understanding ULP-E and needed to repeat statements. ULP-E said he required a translator for communication. On February 3, 2026, at 2:06 p.m., the surveyor	0 470		

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0 470	Continued From page 5 called ULP-D. The surveyor had difficulty understanding ULP-D and needed to repeat statements. ULP-D said he required a translator for communication. On February 4, 2026, at 1:04 p.m., registered nurse (RN)-B said she was the only nurse for the licensee, and she was responsible for staff education and competency evaluations. RN-B said the licensee used computer training for staff education. RN-B said she completed competency training for the ULPs, but required LALD-A to be present so she could translate because of the language barrier. RN-B said the translation was necessary because she wanted the ULP's to completely understand. RN-B said she gave resident information to LALD-A and she would then relay the information to the ULPs due to language barrier. RN-B said ULP's can speak English, but she just wanted to make sure they knew what they were doing and to ensure they completely understood. RN-B said the licensee staffing schedule consists of one ULP at the facility for each working shift. On February 10, 2026, at 1:13 p.m., during a follow up interview, RN-B said LALD-A translates information from her to the licensee's ULPs. RN-B said ULPs could understand the residents, and the residents could understand them. When asked if it was concerning, ULPs could understand the resident's verbal communication, but not RN-B; RN-B said it was concerning, and she told leadership including LALD-A multiple times. RN-B said LALD-A told her, they did not have any other staff members. RN-B said the licensee training program consisted of education modules for ULPs. RN-B said the education modules used English language, and one other language, not the primary language of the	0 470		

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0 470	Continued From page 6 licensee's ULPs. RN-B acknowledged the lack of documentation from the ULP staff and said the ULP's couldn't write good English, and most of the time LALD-A writes any notes. Time Period for Correction: Seven (7) days.	0 470		
0 630 SS=J	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a person-centered individual abuse prevention plan (IAPP) to address mental health needs including self-injurious behavior and substance abuse (street drugs) for one of one resident (R1) with records review. R1 died from a drug overdose. This practice resulted in a level four violation (a violation that harmed a resident ' s health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death) and was issued at an isolated scope (when one or a limited number of residents are	0 630		

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0 630	Continued From page 7 affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's admitted to the licensee on March 20, 2025. R1's service plan dated March 20, 2025, indicated R1 required daily medication administration, daily "I'm OK" check, and "as needed" mental health management. The service plan lacked any indication what R1's mental health needs were. The service plan lacked identification of specific interventions/services the licensee would implement to address mental health issues. The service plan lacked indication of R1's diagnoses. R1's individual abuse prevention plan (IAPP) dated March 20, 2025, was incomplete and contained "blank" sections. But the IAPP indicated R1 had mental illness and developmental disorder. The IAPP indicated R1 had "substance abuse." The IAPP indicated R1 was unable to report abuse, neglect, or exploitation due to developmental disorder. The IAPP indicated R1 was susceptible to abuse from others due to developmental delay and substance abuse. The IAPP indicated R1 was at risk of self-abuse due to chemical abuse. The only interventions identified to manage these issues were for staff to monitor and report changes to the nurse. The IAPP failed to include actions, frequency, duration, or explanation of "monitor." The IAPP failed to identify what observations staff should report to the nurse. The IAPP indicated R1's service plan, or care plan contained interventions to address the vulnerabilities. The IAPP indicated the licensee received this	0 630		

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0 630	Continued From page 8 information from the resident, their own observations, and information they received from another facility. The IAPP failed to identify R1's mental health/illness diagnoses. R1's, Uniform Assessment Tool Sample Form (nursing assessment), dated March 20, 2025, indicated R1's diagnoses included hypertension (high blood pressure), substance abuse, developmental disorder, anxiety, auditory hallucinations, and Schizophrenia. The assessment form contained a section for the nurse to address if R1 used drugs. This section remained blank. The assessment indicated R1 also had suicidal ideation. The assessment indicated R1 used psychotropic medications (used to treat mental health disorders). The assessment indicated R1 had poor decision-making ability. The assessment also contained an additional section for identifying behavior concerns. In this section, the licensee indicated R1 had "self-harm" due to substance abuse. The assessment indicated R1 was withdrawn and self-isolated. The assessment failed to contain any interventions to manage R1's diagnoses including suicidal ideation, and substance use. The assessment lacked indication R1 was physically or verbally aggressive or had any negative behavioral concerns. The assessment indicated the licensee also reviewed this same assessment on April 3, 2025, and on July 1, 2025, and made no changes to R1's service plan. On February 2, 2026, at 10:28 a.m., the surveyor requested documentation including R1's care plan. At 4:19 p.m., the surveyor received a document titled, Care Plan Report, dated January 8, 2025. Upon further inspection, the care plan was from the skilled nursing facility where R1	0 630		

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0 630	Continued From page 9 lived prior to admission to the licensee. The care plan indicated R1 was homeless, and had a history of substance use disorder. Other diagnoses included auditory hallucinations, anxiety, schizophrenia, psychosis, and suicidal ideation. The care plan also indicated R1 required suicide monitoring because he had suicidal thoughts. The care plan indicated a psychologist (mental health physician) recommended staff members observe R1 for signs of drug use including alcohol. Examples of staff observations were to observe R1 for an intoxicated appearance or sleeping throughout the day. R1's county support plan dated February 2, 2025, through October 31, 2025, completed by the licensee, indicated the licensee would provide one-to-one staffing for socialization and staff would manage self-injurious behavior. The support plan indicated R1 had a history of suicide attempts in the past and was at risk of self-neglect, substance use, and low motivation. The support plan indicated R1 required daily supports to maintain his stability and could easily deteriorate if supports were not in place. R1 had multiple mental health behaviors, and was unable to control himself. The licensee indicated they would work with him and redirect him from those kinds of behavior and manage his other mental health needs. R1 had hallucinations and schizophrenia, and the licensee would communicate with him to build relationships and set clear expectations and guidelines. The licensee would implement a behavior plan and offer support as needed following his daily activities and behavior. Progress notes dated October 16, 2025, indicated the licensee sent R1's case manager an updated county support plan.	0 630		

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0 630	Continued From page 10 R1's updated county support plan dated November 1, 2025, valid through October 31, 2026, indicated R1 had anxiety and the licensee would monitor for signs of anxiety and offer coping mechanisms and redirection to help him manage his anxiety. R1 had agitation. The licensee indicated they would encourage him to talk freely about his feelings and help plan alternative ways of handling disappointment, anger, and frustration. The licensee would also provide redirection to him when he has agitation, and they would provide a calm environment. The licensee would offer as needed (PRN) medications and report any changes to the nurse immediately. R1 had a history of suicide attempts, along with past addiction, and isolation. R1's agitation and aggression may increase risk of self-injurious behavior. The licensee would provide supervision, assistance, reminders, and encouragement to support him in coping with these thoughts and not acting upon them. R1 had a history of showing physical aggression through hitting and kicking. The licensee would work towards decreasing the problem associated with physical aggression and the behaviors of hitting, and kicking. R1's records lacked an updated IAPP to reflect R1's behaviors as indicated in the county support plan submitted to the case manager prior to R1's death. The licensee submitted the support plan to R1's case manger eight days before his death. Progress notes dated October 20, 2025, indicated R1 spent the night at a family member's house and would be back in the morning. The progress notes lacked indication what time R1 left the licensee, or returned.	0 630		

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0 630	Continued From page 11 Progress notes dated October 21, 2025, indicated R1 wanted to stay overnight at a family member's house again. The note indicated R1 left the licensee without taking his evening medications. The note indicated R1 wanted to return to the licensee at some point but could not get a ride, so the licensee ordered a ride for him. The note lacked any indication what time these events occurred. There were no further progress notes until October 24, 2025. R1's medical record included a document titled, "Overnight Rounds Sheets", dated October 1, 2025, through October 23, 2025. These documented indicated staff members were to observe R1 every two hours starting at 9:00 p.m. through 7:00 a.m. The document indicated staff last observed R1 on October 23, 2025, at 7:00 a.m. Progress notes dated October 24, 2025, no time, indicated unlicensed personnel (ULP)-D knocked on R1's door because he needed to give him his morning medications. The notes indicated R1 did not respond so ULP-D opened the door and found R1 lying on the floor. ULP-D called emergency services (911). The notes indicated law enforcement said R1 was deceased, and they found drug paraphernalia in his room. Incident report dated October 24, 2025, 1:00 p.m., contained the same information as the progress note, however, did indicated ULP-D was the staff member who found R1 lying on the floor. The incident report failed to provide further investigative information. Law enforcement records indicated they received notification from the licensee on October 24, 2025, at 8:32 a.m., R1 was not breathing. Upon	0 630		

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0 630	Continued From page 12 their arrival, they determined R1 was deceased. The records indicated they found R1 lying on the floor in his room, face down, on his left side. Law enforcement found suspected narcotics on his bed, floor, and nightstand. Law enforcement also found a "crack pipe" on the ground next to his nightstand. Law enforcement records indicated ULP-D told them ULP-E told him he saw R1 at midnight on his floor, as he was at the time officers arrived, but R1 was breathing. ULP-D did not check or observe R1 until 8:30 a.m. Law enforcement records indicated R1 was at a family's home the day prior, but the licensee provided no further information to law enforcement regarding this. R1's death record indicated R1 died October 24, 2025. The cause of death indicated R1 died from cocaine, ethanol, ketamine, fentanyl, and methamphetamine (street drugs). On February 4, 2025, at 1:04 p.m., registered nurse (RN)-B said the licensee kept their service plans/interventions, and individual abuse prevention plans (IAPP) at the licensee's office, not at building where the residents live. RN-B said prior to R1's admission, she knew he was coming from a skilled nursing facility, but did not have a lot of information. Licensed assisted living director (LALD)-A made the decision to accept him. RN-B said she first met R1 when she completed his admission assessment. RN-B said R1 had no history of behavior concerns, but she was aware he had a diagnosis of Schizophrenia. RN-B said R1 had a history of substance use, but he had been sober for about a year. RN-B said the licensee did not have naloxone or comparable product (used to reverse opioid overdose). RN-B said the licensee did not have a system in place to "track" resident "comings" and "goings", staff	0 630		

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0 630	Continued From page 13 just pass this information verbally to other staff, unless residents left for a couple of days. RN-B said she did not see/review the forms staff completed regarding rounds/safety checks, so she could not comment, but staff were to "lay eyes" on the resident every two hours unless they lock their door. On February 10, 2026, at 1:13 p.m., during a follow up interview, RN-B said R1 was "clean" for over one year. RN-B said she gave verbal directions for staff members to call her if he appeared different than usual. RN-B said she directed staff to "monitor" R1 for changes, but could not describe the meaning of "monitor" such as duration and frequency. RN-B said ULPs did not monitor R1 for substance abuse daily, because it was not on the county support plan. RN-B then said ULPs did monitor for it, but they could not obtain payment for the services. RN-B said the licensee had no "tracking system" to identify when resident's leave the building or return. RN-B said she did not believe implementing person centered individualized interventions would have made any difference in the outcome of this incident. On March 4, 2026, at 1:31 p.m., ULP-D said he was unaware R1 had a history of drug use. ULP-D said the licensee did not give him instruction on how to monitor him. On March 4, 2026, at 3:14 p.m., ULP-E said he was unaware R1 had a history of drug use and was unaware of what to "look for." The licensee's policy titled, Individual Abuse Prevention Plan, dated August 20, 2024, indicated the licensee would develop and implement an IAPP for each resident which would	0 630		

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0 630	Continued From page 14 include specific measures to minimize the risk of abuse including self-abuse. Time period for correction: Seven (7) days	0 630		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the	0 730		

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0 730	Continued From page 15 appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to contain accurate records including identifying information for emergency contacts and medical providers 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 admitted to the licensee on March 20, 2025. R1's demographic sheet (face sheet), no date, contained sections for the licensee to add resident information. R1's face sheet included a	0 730		

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0 730	Continued From page 16 section for his physician information. The information indicated the name of the physician, but no phone number or address. The face sheet contained a section to identify R1's family member. The licensee placed the first name of an individual, and their relationship to R1, however the licensee failed to put their last name. The licensee added a phone number for the individual, but no other contact information. The face sheet also included a section for R1's case manager. This section included the first and last name of the individual, however the last name appeared to be incorrect, as it was later discovered the last name listed was the last name of R1's family member. The phone number listed for the case manager was no longer in service. The licensee failed to identify contact information for any other case worker. Progress notes dated October 16, 2025, indicated R1 received a new case manager. The note identified her first name, but no other contact information. R1's record and face sheet lacked identification of this individual and her contact information. On February 10, 2026, at 1:13 p.m., registered nurse (RN)-B said she completed the resident's face sheets at the time of their admission. RN-B said R1 did not have a physician at the time of his admission. He arrived with a one-month supply of his medication, then the licensee had to obtain a physician for him. RN-B said if anything needed to be updated, after she completed the admission paperwork, it would have been the responsibility of the licensed assisted living director (LALD)-A. RN-B then acknowledged it was her responsibility to put medical information on R1's face sheet. RN-B said it was LALD-A's responsibility to update other information including case	0 730		

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0 730	Continued From page 17 managers on the face sheet. RN-B said most of the time the licensee's face sheets were incorrect. Time period for correction: Seven (7) days	0 730		
01760 SS=H	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure they provided accurate, up to date medication administration records (MAR) for two of two residents (R1, R2) with record reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	01760		

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01760	Continued From page 18 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 admitted to the licensee on March 20, 2025. On February 2, 2026, at 10:28 a.m., the surveyor asked licensed assisted living director (LALD)-A for R1's MARs in August, September, and October 2026. On February 2, 2026, at 4:09 p.m., LALD-A sent the surveyor R1's MARs. The documents provided contained a MAR dated August 1, 2025, through August 31, 2025, and September 1 through September 30, 2025. LALD-A failed to include a MAR for October 2025. R1's death record indicated R1 died October 24, 2025. R1's MAR dated November 1, 2025, through November 22, 2025, (after R1's death), indicated staff documented they administered R1's medications November 1, 2025 through November 21, 2025. R2 R2 admitted to the licensee on August 10, 2023. On February 2, 2026, at 8:54 a.m., the surveyor observed the licensee's "medication room." Located in this room were R2's medications. His medication supply contained individual dosage packs provided by the pharmacy. On February 2, 2026, at 9:20 a.m., the surveyor observed a plastic binder located in the	01760		

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01760	Continued From page 19 medication room. The binder contained resident information including R2's MARs for January 2026, but lacked a MAR for February 2026. There was no MAR to record R2's medication administration on February 1, 2026 and February 2, 2026. On February 2, 2026, at 10:28 a.m., the surveyor informed LALD-A about the lack of a February 2026 MAR for R2. LALD-A said she would get it in the book. On February 4, 2026, at 1:04 p.m. registered nurse (RN)-B said the pharmacy sends the licensee the MAR's and she put them in the binder usually a few days before the first of the month. On February 10, 2026, at 3:00 p.m., pharmacist (PH)-G said the pharmacy does not keep record of when MARs go out because it's not a medication, however R1's November MAR would have gone out around October 27th to October 31st. However sometimes they send the MAR with the last dose pack refill. R1's last medication dose pack sent to licensee was on October 2, 2025, so they might have sent the November MAR at that time, but they (licensee) would have already had October MAR because the pharmacy sent it to them in September. On February 10, 2026, at 1:13 p.m., during a follow up interview, RN-B was unsure why there was a discrepancy for R1's November MAR, as he died in October. RN-B said LALD-A changed the MARs in the book where the licensee keeps them because the pharmacy mails the MAR's directly to the licensee. On February 11, 2026, at 9:28 a.m., LALD-A said	01760		

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01760	Continued From page 20 she was unsure why R1's November MAR was signed out because R1 died in October. LALD-A said it must have been an error, but was unsure how the error occurred. LALD-A said the ULP who worked during the morning February 1, 2026, should have put R2's MAR in the book. LALD-A said the ULP told her he forgot. The licensee's policy titled, Medication and Treatment Record-Documentation and Refusal, dated August 20, 2024, indicated the licensee would accurately document medication and treatments in the resident's clinical record. Time period for correction: Seven (7) days	01760		
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: 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 and an individual person were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	Refer to the public maltreatment report sent separately.	