Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356987842M
Compliance #: HL356988343C

Date Concluded: April 9, 2026

Name, Address, and County of Licensee Investigated:
Graceful Lodge Home Care
6430 June Avenue North
Brooklyn Park, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Willette Shafer, 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(s):
The alleged perpetrator (AP) abused the resident when the AP punched and choked resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Resident-1 threatened and attacked the AP; punching, kicking, and choking him. The incident was witnessed by resident-3 and an unlicensed personnel who both said resident-1 attacked the AP. The witnesses and the AP stated the AP did not harm resident-1.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted resident-1's in-home service worker. The investigation included review of resident records, facility incident reports, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator toured the facility and observed interactions between the residents and staff.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia, bipolar disorder, congenital brain defect, post-traumatic stress disorder, attention-deficit/ hyperactivity disorder, depression, and anxiety.

Resident-1's service plan included assistance with medication management, meal preparation, and housekeeping. He required reminders for personal cares and behavioral interventions.

The facility's incident report indicated during dinner resident-1 was redirected after he was verbally aggressive towards another resident. Resident-1 went outside to smoke. As the AP was leaving, resident-1 threatened him. Resident-1 ran towards the AP and attacked him; punching, kicking, and knocking the AP's glasses off. Resident-1 threw the AP's laptop off the deck into the yard. Resident-3 and an unlicensed personnel were present. They yelled for resident-1 to stop. The police were called. During the incident, resident-1 broke the door, the window, and the blinds. Resident-1 had numerous past assaults and uncontrolled outbursts. Several facility residents voiced concerns about resident-1's behavior.

The police report indicated they responded to an assault call at the facility. The 911 caller reported resident-1 choked the AP. When the police arrived, the unlicensed personnel reported resident-1 attacked the AP. Resident-1 was arrested and charged with fifth degree assault. Resident-1 reported he was redirected away from another resident, and he became angry. Resident-1 warned facility staff he would assault them if they continued to tell him what to do. Resident-1 reported staff "instigated" the incident by enforcing the rules. Resident-1 reported staff "pushed him away". Resident-1 was brought to the hospital for a mental health evaluation per his request.

During an interview, resident-1 said he was upset about a conversation at dinner and went to smoke with resident-3. He told resident-3 he was going to "whoop his ass" referring to the AP. Resident-1 called the AP racial slurs and threatened him. Resident-1 said he ran towards the AP with his fists in the air and the AP choked him and hit him. The police came and took resident-1 to the hospital for psychiatric evaluation. Resident-1's criminal history included assault and terroristic threat charges. Resident-1 said he was six feet two inches tall and weighed 270 pounds. He described the AP as five foot seven inches tall and weighed 180 pounds. Resident-1 still lived at the facility and felt safe there.

During an interview, the AP said resident-1 became upset at dinner and verbally abused another resident. The AP redirected resident-1, and he became upset. As the AP was leaving for the day, resident-1 began yelling and threatening the AP. Resident-1 started punching the AP. The AP tried to protect himself by blocking resident-1's punches. The AP tried to get away from resident-1 until the police arrived. Resident-1 bit the AP's hand and broke his skin. After the incident, the AP was sore and bruised. Resident-1 was brought to the hospital for a mental health evaluation. The AP stated he never hit or choked resident-1. Resident-1 had a significant history of aggression towards others, and several interventions were identified and documented to help him de-escalate.

During an interview, resident-2 said she was at the bottom of the stairs during the incident. Resident-1 and the AP were at the top of the stairs, but she only saw their heads moving. Resident-1 was yelling racist comments at the AP. The unlicensed personnel yelled for help and said resident-1 attacked the AP. A few weeks prior to this incident, resident-1 physically assaulted resident-2. Resident-1 pushed resident-2 against the wall causing injuries. The police came and she pressed charges against resident-1. She said the AP was very kind and soft-spoken. He would never harm a resident.

During an interview, resident-3 said she went to smoke with resident-1 after dinner. Resident-1 was agitated and said he was going to “choke” the AP. Resident-1 “attacked” the AP. He hit the AP’s head against the couch and tried to choke the AP. Resident-1 threw a piece of glass at the AP and threw the AP’s computer out the door. She moved out of the facility because she feared resident-1. She described resident-1 as dangerous and unpredictable.

During an interview, the unlicensed personnel said she observed the incident. Resident-1 became agitated after he was redirected away from another resident during dinner. Resident-1 “rushed at” the AP and began hitting the AP. The AP was trying to get away from resident-1. Resident-1 knocked the AP’s glasses off his face and held the AP on the ground. Resident-1 broke a piece of glass out of the door and threw the AP’s laptop out the door. The police came and took a report. She said everyone was scared because resident-1 was huge and the AP was a “little man.” The AP never punched, hit, or choked resident-1. She said resident-1 had a history or aggression towards others.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No, declined interview request.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an incident report, met with resident-1 to develop a safety plan, and updated resident-1’s service plan.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments On March 23, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL356988343C/#HL356987842M. No correction orders are issued.	0 000		