Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL357151320M
Compliance #: HL357155620C

Date Concluded: April 14, 2026

Name, Address, and County of Licensee Investigated:
All Hopes Inc
7932 Orchard Ave N
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when staff failed to provide adequate supervision. The resident overdosed on cocaine and fentanyl while smoking a cigarette. A fire started in the resident's bed, resulting in the facility being uninhabitable.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility staff failed to develop and implement interventions despite knowledge of the resident's illegal drug use and unsafe smoking practices. A fire started in the resident's room after the resident became unconscious while smoking and using illegal substances. The fire department was contacted and assisted with evacuation of the facility. The residents were relocated due to the extent of the fire damage.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted two case managers and the

primary care provider. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement reports, and related facility policy and procedures. Also, the investigator observed the damaged facility. An engineering staff member was given access to the inside of the facility and observed the room where the fire started.

The resident resided in an assisted living facility. The resident's diagnoses included mood disorder and paranoid schizophrenia. The resident's service plan included assistance with behavior management for agitation, anxiety, elopement threat, verbal aggression, delusions, paranoia, other mental health need, 27 safety checks per day, and medication administration. Safety check tasks included staff performing a visual check of the resident every hour to make sure he was safe due to history of suicidal thoughts, drug use and to make sure he was not smoking in his room. It was also noted the resident used substances like cocaine, fentanyl, and marijuana.

The resident's assessment indicated the resident "denies smoking" but staff would monitor. A smoking assessment was not completed as the resident denied he smoked. It was noted the resident "takes drugs." The resident had a past overdose on opioids. Staff were to continue with safety checks and monitor for substance use. The assessment failed to identify that the resident had an order for as needed/PRN Naloxone/Narcan nasal spray to be used for suspected overdoses. No interventions to reduce harm to the resident or reduce the risk of illegal substance use were identified.

Progress notes indicated the resident was observed smoking in his room by facility staff on at least two occasions in the weeks leading up to the fire. Staff documented they tried to redirect the resident, but it was not effective. Staff also observed him smoking marijuana in the facility.

The resident's service recap summary indicated the day before the fire, the resident was intoxicated with alcohol, was loud, disruptive and displayed "bizarre behavior." The month before the fire, it was noted 17 times that the resident was intoxicated with alcohol, was loud and disruptive and displayed "bizarre behavior." The resident also had consistent behaviors of attempting to leave the facility, hearing things that others could not hear, having false beliefs, excessive movement or eating, angry outbursts, was loud and not redirectable. The resident's record lacked evidence the nurse was notified of these behaviors or what interventions were utilized when the resident displayed the behaviors.

A report from the police department indicated 911 was called at 1:27 a.m. with the caller reporting the room was on fire and the resident was still in the room on the floor. Two police officers arrived at the facility and observed heavy black smoke billowing out of the resident's room. The door was closed and when officers opened it, the resident was observed lying on the ground and appeared unresponsive. Officers dragged the resident down the hallway and brought him outside and at that time, the bedroom became fully engulfed, and fire began shooting out of the bedroom window. The resident was not conscious and had agonal

breathing. The resident also displayed “pinpoint” pupils and officers suspected he was experiencing some sort of overdose. Narcan was administered and within a minute, the resident opened his eyes and tried to sit up. The resident was then taken to the hospital. An officer visited with staff who reported they went to check on the resident and noted his bed to be on fire. The staff reported they knew the resident used various narcotics, including smoking marijuana and other things, and knew the resident had Narcan in his bedroom. The staff member reported he got the other residents out of the facility

A report from the fire department indicated a call for a structure fire was received at 1:27 a.m. The fire department report indicated they interviewed an unidentified staff member who reported that the resident smokes and uses drugs in his room often. The staff member heard some commotion in the room and went to check, but the door was locked and it was not supposed to be locked. The staff member got the door open and observed the resident laying on the floor and was not responsive and there was a fire on the bed near the window. The other staff member assisted with getting everyone out of the facility. The police went into the facility and pulled the resident out of his room and into the yard. The resident was noted to be unresponsive during the rescue. When unidentified staff members were interviewed by the fire inspector, the staff reported there were behavioral concerns with the resident including locking the bedroom door, smoking inside the room near the window, suspected drug use in the room, and returning to the group home [assisted living facility] under the influence. The cause of the fire was noted to be possibly impaired by alcohol or drugs with misuse of material or product. The cause of the fire was "smoking materials/illicit drugs" When fire crews arrived, police officers were "dragging a victim out."

Hospital records indicated the resident was evaluated in the emergency room for smoke inhalation and accidental opioid overdose. The drug screen was positive for cocaine and fentanyl. The resident did not return to the facility after being medically cleared.

During an interview, ULP #1 stated he was working the overnight shift when the fire started and the resident came down to the kitchen a few times to get food then went back to his room. ULP #1 stated when he was doing safety checks, he found the fire in the resident’s room and he called out to the resident but he didn’t respond. ULP #1 stated there was another resident room close to the fire, so he went and evacuated the other residents and called 911. ULP #1 stated he had never seen the resident smoke in his room but one day he had smelled smoke in his room and asked the resident if he had been smoking in his room, but he denied it. ULP #1 stated the resident always denied that he’d done something, even if it was clear he had done it.

During an interview, ULP #2 stated you could tell the resident not to smoke in the facility and to go outside but he would refuse. ULP #2 stated if he wanted to smoke, he'd lock his bedroom door and would refuse to open the door for staff. ULP #2 stated the resident never listened to staff but if the supervisor or director was around he'd listen but as soon as they left, he wouldn't listen to staff. ULP #2 stated when the resident came back to the facility under the influence, he would be stiff and stand for two or three minutes before he could move and then

he would go to the kitchen and eat all the food. ULP #2 stated the resident would sometimes leave the facility for 2 or 3 days and he'd come back and smoke in his room and he'd lock the door so staff couldn't open it. ULP #2 stated the resident would sleep on the bed and smoke on top of the bed and if you asked him to stop, he did not listen.

During an interview, the resident's mental health case manager stated she met with the resident about once a month to discuss his goals. The case manager stated the resident reported he was sober and had not been using any substances. The case manager stated the resident expressed he wanted to do what he could to get off his commitment and do what the court wanted him to do so she believed he had been sober. The case manager stated she was not previously aware of concerns with the resident returning to the facility under the influence or that staff observed him smoking in the facility. The case manager stated she would expect to be updated on information like that.

During an interview, the registered nurse (RN) stated she worked at the facility every day except weekends. The RN stated the resident isolated a lot in his room and left without letting staff know where he was going. The RN stated the resident was into drugs and he had previously passed out from drug use. The RN stated she had not actually seen the resident use any illegal substances but thought he might use meth. The RN stated staff had not reported any concerns to her of the resident smoking in the facility. The RN stated as part of her role, she reviewed progress notes but she did not see the progress notes about the resident smoking in his room until after the fire happened. The RN stated the resident's assessment did not reflect he was a smoker because the resident denied smoking.

During an interview, the facility director stated the resident often left the facility and returned under the influence of substances. The director stated the resident's substance use was a problem and staff had been trained on how to use Narcan. The director stated smoking was not allowed in the facility and he couldn't say if the resident smoked in his room. However, the director stated they found cigarette butts in his room but the resident denied smoking in there and said he saved them for later. The director stated as part of his job, he reviewed resident progress notes but he did not recall ever seeing any notes that indicated the resident smoked in his room. The director stated the other director or clinical nurse supervisor would also review notes and if they saw anything they would address it.

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: Unable to locate
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The residents were relocated to an unlicensed home in a nearby neighborhood. The facility filed a MAARC report.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department
Minnesota Board of Nursing
Minnesota Board of Executives for Long Term Services and Supports
MN Department of Human Services, Office of Inspector General, Surveillance Integrity Review Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35715	A. BUILDING: _____ B. WING _____	C 02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL HOPES INCORPORATED	7932 ORCHARD AVENUE NORTH BROOKLYN PARK, MN 55443

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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: #HL357155621C #HL357151320M/#HL357155620C On February 18, 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 zero residents receiving services under the provider's Assisted Living license. Three residents were receiving services at an alternate site. The following correction orders are issued for #HL357151320M/#HL357155620C, tag identification 0810, 2310, 2360 The following correction order is issued for #HL357155621C, tag identification 0820	0 000		
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810		

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0 810	Continued From page 1 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents,	0 810		

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0 810	Continued From page 2 staff, and visitors. 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 8, 2025, the licensee received an enforcement letter, with the results of the survey completed May 14, 2025. The longest time period for correction was 21 days from July 8, 2025. The licensee was cited under tag 0810 for failing to have a fire safety and evacuation plan (FSEP) with the required content. The citation indicated the facility fire safety and evacuation plan did not include all required content and indicated the licensee's FSEP, titled "Fire Safety", dated December 15, 2022, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.	0 810		

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0 810	Continued From page 3 The licensee's documentation of action take to correct the May 14, 2025, citations was reviewed. The documented action taken to resolve tag 0810 was "staff actions in fire and other emergencies developed. Actions of staff and clients [residents] outlined and included in FSEP." A completion date of June 5, 2025, was listed. On February 2, 2026, a fire occurred at the facility. On February 18, 2026, the licensee's fire safety and evacuation plan (FSEP) and fire and evacuation drills for the facility were reviewed. An undated document titled Resident's Responsibilities During a Fire Emergency indicated residents should acknolwedge the alarm promptly and follow evacuation instructions. The policy failed to provide specific resident actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The policy lacked instructions including but not limited to primary exit routes, secondary exit routes, occupant assembly point outside the building, and what to do if evacuation is not possible. On March 2, 2026, at 11:30 a.m., licensed assisted living director in residence (LALDIR)-B stated licensed assisted living director/registered nurse (LALD/RN)-A was responsible for the licensee's action to correct previously issued citations. No further information was provided. Time Period for Correction: Two (2) Days	0 810		

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0 820	Continued From page 4	0 820		
0 820 SS=L	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level four violation (a violation 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated	0 820		

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0 820	Continued From page 5 2/18/2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 820		
02310 SS=L	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted 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: The licensee failed to ensure appropriate care and services were provided based on resident needs and accepted health care standards for one of one resident (R1) when staff failed to develop and implement interventions for R1's known history of unsafe smoking practices and drug use. The resident became unconscious while smoking and a fire started resulting in the facility needing to be evacuated. This practice resulted in a level four violation (a violation 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included mood disorder and paranoid schizophrenia.	02310		

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02310	Continued From page 6 R1's service plan dated September 18, 2025, indicated the resident received assistance with behavior management for agitation, anxiety, elopement threat, verbal aggression, delusions, paranoia, other mental health need, 27 safety checks per day, and medication administration. Safety check tasks included staff performing a visual check of the resident every hour to make sure he was safe due to history of suicidal thoughts, drug use and to make sure he was not smoking in his room. It was also noted the resident would use substances like cocaine, fentanyl, and marijuana. R1's most recent assessment dated December 30, 2025, indicated the resident "denies smoking" but staff would monitor. A smoking assessment was not completed as the resident denied he smoked. It was noted the resident "takes drugs." R1 had a past overdose on opioids in February. Staff were to continue with safety checks and monitor for substance use. The assessment failed to identify that R1 had an order for as needed/PRN Naloxone/Narcan nasal spray to be used for suspected overdoses. No interventions to reduce harm to the resident or reduce the risk of illegal substance use were identified. R1 had a history of eloping from the facility and being arrested. No interventions to reduce the risk of elopements besides redirection were identified. R1 had a history of violence including fights. Interventions included monitoring, removing self, and calling 911. If the resident had behaviors, staff were to redirect. The assessment failed to identify what redirection techniques were to be used. The assessment did not identify that R1 was at the facility on a civil commitment with a Jarvis hold (when a person with mental illness does not want to take medication, the court can	02310		

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02310	Continued From page 7 order them to take medication). R1's medication administration record (MAR) contained an order for as needed/PRN Naloxone/Narcan nasal spray for suspected overdoses. Staff were to place one spray in on nostril and a second spray in the other nostril if no response after 2 to 3 minutes. The spray had not been given in January or February 2026. On January 25, 2026, staff wrote R1 was in his room smoking and "everywhere smelling" as the shift started. Staff redirected R1 and let him know that smoking was not allowed in the facility but R1 didn't stop and "repeated same thing in the afternoon lucked [locked] his door as staff trying to correct him." R1 was in his room smoking when the staff member finished her shift. On January 3, 2026, staff wrote that when they arrived for their shift, R1 was observed to be smoking marijuana in his room and staff told him to stop. R1's service recap summary for January 2026 indicated on January 2, January 3, January 11, January 14, January 15, January 16, January 17, January 18, January 21, January 22, January 23, January 25, January 26, January 28, January 29, January 30, and January 31, 2026, R1 was intoxicated with alcohol, was loud and disruptive and displayed "bizarre behavior." R1 also had consistent behaviors of attempting to leave the facility, hearing things that others could not hear, having false beliefs, excessive movement or eating, angry outbursts, and loud and not redirectable. R1's service recap summary for February 2026 indicated in February 1, 2026, R1 was intoxicated	02310		

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02310	Continued From page 8 with alcohol, was loud and disruptive and displayed "bizarre behavior." A report from the police department indicated 911 was called at 1:27 a.m. on February 2, 2026, with the caller reporting the room was on fire and the resident was still in the room on the floor. Two police officers arrived at the facility and entered the facility where they observed heavy black smoke billowing out of R1's room. The door was closed and when officers opened it, R1 was observed lying on the ground and appeared to be unresponsive. Officers dragged the resident down the hallway and brought him outside and at that time, the bedroom became fully engulfed and fire began shooting out of the bedroom window. R1 was not conscious and had agonal breathing. R1's pupils appeared to be pinpoint and the officers suspected he was experiencing some sort of overdose. Narcan was administered and within a minute, R1 opened his eyes and tried to sit up. R1 was then taken to the hospital. An officer visited with staff who reported they went to check on R1 and noted his bed to be on fire. The staff reported they knew R1 to use various narcotics, including smoking marijuana and other things, and knew R1 had Narcan in his bedroom. The staff member reported he got the other residents out of the facility A report from the fire department indicated a call for a structure fire was received on February 2, 2026, at 1:27 a.m. The fire department report indicated they interviewed an unidentified staff member who reported that R1 smokes and uses drugs in his room often. The staff member heard some commotion in the room and went to check, but the door was locked and it was not supposed to be locked. The staff member got the door open and observed R1 laying on the floor and was not	02310		

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(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
02310	Continued From page 9 responsive and there was a fire on the bed near the window. The other staff member assisted with getting everyone out of the facility. The police went into the facility and pulled R1 out of his room and into the yard. R1 was noted to be unresponsive during the rescue. When unidentified staff members were interviewed by the fire inspector, the staff reported there were behavioral concerns with R1 including locking the bedroom door, smoking inside the room near the window, suspected drug use in the room, and returning to the group home [assisted living facility] under the influence. The cause of the fire was noted to be possibly impaired by alcohol or drugs with misuse of material or product. The cause of the fire was "smoking materials/illicit drugs" When fire crews arrived, police officers were "dragging a victim out." Progress notes indicated R1 was observed smoking in his room by facility staff on at least two occasions in the weeks leading up to the fire. Hospital records indicated R1 was evaluated in the emergency room for smoke inhalation and accidental opioid overdose. A drug screen was positive for cocaine and fentanyl. R1 did not return to the facility after being medically cleared. On March 2, 2026, at 10:30 a.m., unlicensed personnel (ULP)-F stated R1 didn't like to listen and if you tried to tell him not to go out of the facility, he would say no I want to go you can't direct me, this is my house I pay for my house I can do what I want. ULP-F stated R1 didn't listen to staff and he'd go out and come back intoxicated and they weren't able to direct him. ULP-F stated you could tell R1 not to smoke in the facility and to go outside but he would refuse. ULP-F stated if he wanted to smoke, he'd lock his	02310		

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	35715	A. BUILDING: _____ B. WING _____	C 02/18/2026

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02310	Continued From page 10 bedroom door and would refuse to open the door for staff. ULP-F stated R1 never listened to staff but if the supervisor or director was around he'd listen but as soon as they left, he wouldn't listen to staff. ULP-F stated staff would beg him to take his medications and he would refuse and would always refuse to take his medication. ULP-F stated when R1 came back to the facility under the influence, he would be stiff and stand for two or three minutes before he could move and then he would go to the kitchen and eat all the food. ULP-F stated R1 would sometimes leave the facility for 2 or 3 days and he'd come back and smoke in his room and he'd lock the door so staff couldn't open it. ULP-F stated R1 would sleep on the bed and smoke on top of the bed and if you talked to him he said he'd would not listen. On March 2, 2026, at 10:45 a.m., clinical nurse supervisor (CNS)-E stated she worked at the facility every day except weekends. CNS-E stated R1 would isolate a lot in his room and would leave without letting staff know where he was going. CNS-E stated R1 was into drugs and he had previously passed out at a Burger King from drug use. CNS-E stated she had not actually seen R1 use any illegal substances but thought he might use meth. CNS-E stated staff had not reported any concerns to her of R1 smoking in the facility. CNS-E stated as part of her role, she would review progress notes but she did not see the progress notes about R1 smoking in his room until after the fire happened. CNS-E was asked if R1 was on any kind of commitment or Jarvis hold and she stated LALD-A would know. CNS-E stated R1 would sometimes get really aggressive and interventions included having staff tone it down, assure him you're not invading his privacy, or reapproach him. CNS-E stated R1's assessment did not reflect he was a smoker	02310		

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02310	Continued From page 11 because R1 denied smoking. CNS-E stated R1 would sometimes tell you one thing and the next minute say something different. On March 2, 2026, at 11:15 a.m., R1's mental health case manger (CM)-D stated she would meet with R1 about once a month to discuss his goals. CM-D stated R1 reported he was sober and had not been using any substances. CM-D stated R1 expressed he wanted to do what he could to get off his commitment and do what the court wanted him to do so she believed he had been sober. CM-D stated she was not previously aware of concerns with R1 returning to the facility under the influence or that staff had observed him smoking in the facility. CM-D stated she would expect to be updated on information like that. On March 2, 2026, at 11:30 a.m., licensed assisted living director in residence (LALDIR)-B stated R1 would often leave the facility and return under the influence of substances but he was not sure exactly what. LALDIR-B stated R1's substance use has been a problem and staff had been trained on how to use Narcan. LALDIR-B stated he was not sure if R1 was on a commitment but the facility had other residents on commitments and they were able to manage that level of care. LALDIR-B stated smoking was not allowed in the facility and he couldn't say if R1 smoked in his room because while they found cigarette butts in there, R1 denied smoking in his room and said he had just saved them for later. LALDIR-B stated as part of his job, he would review resident progress notes but he did not recall ever seeing any notes that indicated R1 had been smoking in his room. LALDIR-B stated the director or clinical nurse supervisor would also review notes and if they saw anything they would address it.	02310		

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02310	Continued From page 12 On March 2, 2026, at 1:40 p.m., R1's case manager (CM)-C stated the facility had not updated her on any concerns documented in the resident's record and she was not aware of any concerns with smoking or substance use. CM-C stated she was not immediately updated about the fire and she had to ask a few times to get the incident report from the fire. On March 2, 2026, at 2:15 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he normally worked at the facility every day. LALD/RN-A stated sometimes R1 would be agitated and refuse to do things. LALD/RN-A stated R1 had a past history of an overdose and he would come back to the facility at times under the influence. LALD/RN-A stated they weren't sure what R1 was under the influence of. LALD/RN-A stated they had found cigarette butts in R1's room before but the resident denied smoking in the facility and just said that he got the butts from outside. LALD/RN-A stated R1 denied that he smoked. LALD/RN-A stated that he would read progress notes but did not recall seeing any notes that said the resident was smoking in the facility. LALD/RN-A stated part of R1's safety checks included checking that R1 was not smoking in his room but R1 maintained he did not smoke. On March 4, 2026, at 10:20 a.m., ULP-G stated he was working the overnight shift when the fire started and the resident had come down to the kitchen a few times to get food then went back to his room. ULP-G stated when he was doing safety checks, he found the fire in the resident's room and he called out to the resident but he didn't respond. ULP-G stated there was another resident room close to the fire so he went and	02310		

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02310	Continued From page 13 evacuated the other residents and called 911. ULP-G stated he had never seen the resident smoke in his room but one day he had smelled smoke in his room and asked the resident if he had been smoking in his room but he denied it. ULP-G stated the resident would always deny that he'd done something, even if it was clear he had done it. The licensee's Smoking Policy dated October 17, 2025, indicated smoking was only allowed in designated, well-ventilated outdoor areas. Resident's smoking ability would be assessed on admission and during nursing assessments and reassessments per facility assessment policy, usually every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
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 residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the	02360	No plan of correction required for this tag.	

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02360	Continued From page 14 maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		