Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL375672303M
Compliance #: HL375673969C

Date Concluded: May 22, 2025

Name, Address, and County of Licensee Investigated:
Garden Home AL LLC
16612 Seymore Drive
Minnetonka MN, 55345
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, 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), an unknown facility staff member, sexually abused the resident when they raped her.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined sexual abuse was not substantiated. The resident made multiple allegations of rape against multiple individuals which were untrue. The resident had a significant mental health history which contributed to these allegations.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and a case worker. The investigation included review of the resident records, personnel files, staff schedules, law enforcement reports, and related facility policy and procedures Also, the investigator toured the facility and observed medication administration and interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included depression and anxiety. The resident's service plan included assistance with medications, bathing, housekeeping, laundry, and behavior management. The resident required assistance due to "hoarding" behavior. The resident's nursing assessment indicated she walked independently with a walker but used a wheelchair occasionally when not at the facility. The resident made accusatory statements toward others of abuse, sexual abuse and theft.

The facility records lacked information from the resident's primary physician, but the surveyor obtained these records. The resident's physician records indicated her diagnoses also included a closed head injury, borderline personality disorder, obsessive compulsive disorder (OCD), and schizophrenia.

Law enforcement records indicated the resident called law enforcement 35 times in approximately four months. Law enforcement records indicated the resident told them someone raped her and cut her head off. Other reports included allegations of theft and physical assault by another resident in the home. Law enforcement did not have evidence to charge.

The resident's progress notes indicated there was verbal yelling and threatening from the resident towards other residents and staff. There was not evidence in the resident's record anyone attacked or harmed the resident. The resident's behaviors were communicated to the resident's case manager.

The facility placed functioning cameras in common areas and review video footage when allegations occur.

During an interview, a manager said the resident had a traumatic brain injury and her behaviors included "rage" episodes and accusatory statements. The manager said the resident accused neighbors, residents, staff, and police officers of rape, but no incidents occurred. The manager said the resident accused people of these actions when they were not even at the facility. The manager said there was no evidence such incidences occurred. The manager said the resident called law enforcement multiple times on her own accord but was also accusatory of them when they responded. The manager said the resident's case worker will not come to the facility unless she has security or law enforcement with her due to the resident's behavior.

During an interview, a nurse said the resident refused to attend medical appointments and was not receiving mental health care.

During an interview, the resident said staff members raped her twice but was unable to give further detail about those incidences.

In conclusion, the Minnesota Department of Health determined sexual 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;
(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; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(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. Not Applicable.
Alleged Perpetrator interviewed: No. Not Applicable.

Action taken by facility:

The facility placed functioning cameras in common areas and review video footage when allegations occur.

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37567	A. BUILDING: _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN HOME AL LLC	16612 SEYMORE DRIVE MINNETONKA, MN 55345

(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: HL375673520C/HL375677822M HL375673969C/HL375672303M HL375674028C On April 29, 2025 and May 8, 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 four residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL375673520C/HL375677822M, and HL375673969C/HL375672303M, tag identification 330. The following correction order is issued for HL375673969C/HL375672303M, tag identification 630.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 The following correction is issued for HL375674028C, tag identification 470.	0 000		
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide clinical records and incident reports for three of four residents (R2, R4, R5) 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 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: INCIDENT REPORTS R2 admitted to the licensee for diagnoses including depression, anxiety, chronic pain,	0 330		

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0 330	Continued From page 2 hypertension, heartburn and muscle spasms. R2's service plan dated April 29, 2025, indicated she required behavior management for hoarding, agitation, and verbal aggression. R4 admitted to licensee for diagnoses including depression, schizophrenia, anxiety, and substance use disorder. R4's service plan dated October 16, 2024, indicated he required behavior management for anxiety and depression. Law enforcement records dated January 1, 2025, through May 7, 2025, indicated R2 called law enforcement 35 times. The records indicated R2 made accusatory statements of rape, physical assault, and theft. Law enforcement made 24 reports from these calls. The records indicated R2 made multiple claims R4 physically assaulted and stole from her. Law enforcement records described R2 as "irate", and her behaviors included "yelling" and "cussing." Examples of the incidents R2 reported to law enforcement included: -January 30, 2025, at 4:53 p.m., R2 told law enforcement someone raped her and cut off her head. -February 21, 2025, at 12:40 p.m., R2 yelled at R4, and they used very "colorful" language with each other. -February 22, 2025, at 1:20 p.m., R2 told law enforcement R4 pushed her against a wall. -April 19, 2025, at 3:39 p.m., R2 told law enforcement R4 took pop out of her room, she hit door, then he "threw" her into a chair. On April 29, 2025, at 9:00 a.m., R2 showed the surveyor a yellow and purple bruise on the back of her right shoulder. R2 told the surveyor R4 pushed her to the ground, and she hit a steal chair. R2 told the surveyor "guys" raped her twice	0 330		

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0 330	Continued From page 3 and then went to Egypt. On April 29, 2024, at 12:00 p.m., the surveyor gave house manger (HM)-C a request for documentation. The documentation request included incident reports from October 2024 through December 2024. HM-C did not provide incident reports. On April 30, 2025, at 9:18 a.m., the surveyor sent licensed assisted living director (LALD)-B an email and requested the licensee's incident reports concerning R2 for the last three months. During an interview on April 30, 2025, at 11:58 a.m., LALD-B said the licensee's incident reports were located in a "quality improvement" folder and she would provide them to the surveyor. LALD-B said the folder contained records of R2's calls to law enforcement. LALD-B failed to provide incident reports. On May 9, 2025, at 12:04 p.m., LALD-B said R2's behavior included rage, sexual assault allegations, fighting, and yelling. LALD-B said R2 accused the licensee's staff of sexual assault and R4. Also, R2 was physically aggressive with R4. On May 12, 2025, at 11:26 a.m., the surveyor sent LALD-B and email and requested the licensee's incident reports concerning R2 for the last three months. LALD-B failed to provide incident reports. R5's RECORDS On April 29, 2025, the surveyor entered the facility for a complaint visit. The residents' records were not available onsite. HM-C said the surveyor should contact LALD-B for records.	0 330		

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0 330	Continued From page 4 On May 1, 2025, at 12:22 p.m., surveyor spoke to LALD-B and requested R5's clinical records (face sheet, care plan, service plan, nursing assessment). The surveyor did not receive R5's clinical records. The surveyor spoke to LALD-B again on May 9, 2025, at 2:01 p.m., LALD-B said she would send the surveyor R5's records. The surveyor did not receive R5's records. On May 13, 2025, at 8:28 a.m., the surveyor sent LALD-B an email requesting R5's individual abuse prevention plan (IAPP) the email indicated the surveyor requested the information by noon on May 13, 2025. The surveyor received R5's IAPP from LALD-B on May 14, 2025, at 12:25 a.m. The previously requested records for R5 were not provided. The licensee's policy titled, Clinical Records, dated January 25, 2025, indicated clinical records would be maintained in such a manner that allows for timely access, printing, or transmission. TIME PERIOD OF CORRECTION: Two (2) Days	0 330		
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	0 470		

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0 470	Continued From page 5 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 record review, the licensee failed to ensure they had an awake staff person 24 hours per day seven days per week, who was responsible for providing the health and safety needs of four of four residents (R2, R3, R4, R5) 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 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:	0 470		

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0 470	Continued From page 6 R2 admitted to licensee for diagnoses including depression and anxiety. R2's service plan dated April 29, 2025, indicated she required behavior management for hoarding, agitation, and verbal aggression. R3 admitted to licensee for diagnoses including cerebral infarction, heart disease, hemiparesis, and hemiplegia. R3's service plan dated September 23, 2024, indicated he required behavior management for agitation, anxiety, and visual hallucinations. R4 admitted to licensee for diagnoses including depression, Schizophrenia, anxiety, and substance use disorder. R4's service plan dated October 16, 2024, indicated he required behavior management for anxiety and depression. On May 1, 2025, at 12:22 p.m., the urveyor requested R5's documentation from licensed assisted living director (LALD)-B, and again on May 9, 2025, at 2:01 p.m. No documentation was provided. On April 29, 2025, at 6:55 a.m., the surveyor arrived at the licensee and knocked and rang the doorbell. At 7:00 a.m., house manager (HM)-C answered the door and said he was the only staff working at the time of the surveyor's arrival. HM-C said, there was another person working during the night, but he left the facility at 6:00 a.m. On April 29, 2025, at 7:00 a.m., the surveyor observed the posted staffing schedule, which indicated the licensee scheduled only one staff person during the night shift. HM-C said the staffing schedule was not accurate. HM-C removed the staffing schedule, and hand wrote a	0 470		

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0 470	Continued From page 7 name into the scheduled night shifts and provided it to the surveyor. HM-C said one staff member was awake on night shift, if the other staff member sleeps. On April 30, 2025, at 11:58 a.m., LALD-B said the licensee has twelve-hour shifts for staff members (8:00 a.m. to 8:00 p.m., then 8:00 p.m. to 8:00 a.m.) LALD-B said the facility always has two staff members present during the night shift because they admitted another resident (R5). On May 1, 2025, at 12:22 p.m., LALD-B said she reviewed video footage from during the night (April 28, 2025, to April 29, 2025) and there were two staff present in the home. One staff member left the facility at 6:00 a.m., while the other remained. LALD-B said there was one staff member awake when the other was sleeping and there were no laws against that. The facility did not provide the video footage when requested. On May 1, 2025, at 2:15 p.m., HM-C said the licensee has two staff members working on night shift, but this started recently because the licensee had a new resident (R5) who required two staff to assist him. On May 8, 2025, at 5:49 a.m., the surveyor arrived at the licensee and attempted to gain entry by knocking and ringing the doorbell at the following times: -5:49 a.m. -5:53 a.m. -5:56 a.m. -5:59 a.m. -6:03 a.m. -6:05 a.m.	0 470		

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0 470	Continued From page 8 -6:10 a.m. -6:23 a.m. -6:26 a.m. On May 8, 2025, at 6:27 a.m., unlicensed personnel (ULP)-D answered the door. ULP-D said he was the only person working during the night. ULP-D said HM- C was going to arrive at 8:00 a.m. today (May 8, 2025). The surveyor observed pillows and blankets on the couch in the living area. When asked if he slept, ULP-D said "A little bit". On May 8, 2025, at 6:49 a.m., HM-C called surveyor and said there was another staff member scheduled to work last night, however he "called off" and the licensee did not replace him with a different worker. On May 8, 2025, at 6:54 a.m., HM-C called surveyor again and said the licensee uses the second staff member at night for support, but they "rely" on the first staff member. HM-C said when the licensee admitted R5, they started having two staff at nighttime. HM-C acknowledged R5 used a Hoyer (mechanical) lift, but said he did not require transfers during the night. When surveyor asked what actions would occur during an emergency situation, HM-C said R5's wife was present during the night (at times), and she was a "big help." HM-C said he was unaware what R5's assessed nursing needs were. On May 8, 2025, at 3:00 p.m., LALD-B said she would check the video footage and inform surveyor what she observed. No further response received. On May 13, 2025, at 7:39 a.m., the surveyor sent	0 470		

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0 470	Continued From page 9 LALD-B an email and requested the licensee's staffing policy. At 3:26 p.m., the surveyor spoke to LALD-A who acknowledged she received the email, and said she would send the policy. No policy was received. TIME PERIOD FOR CORRECTION: Two (2) days.	0 470		
0 630 SS=I	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 ensure the individualized abuse prevention plans (IAPP) accurately reflected the resident's vulnerabilities, and failed to implement person centered, individualized interventions to minimize the risk of abuse/harm for three of four residents (R2, R3, R4,) with records reviewed. This deficient practice had the potential to cause serious injury. R2 had violent behavior which posed a risk of abuse to all residents, staff, and visitors.	0 630		

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0 630	Continued From page 10 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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: R2 R2's service plan dated April 29, 2025, indicated she required behavior management for hoarding, agitation, and verbal aggression. The surveyor obtained R2's medical records from R2's physician. Physician records dated December 13, 2024, at 7:24 a.m., indicated R2's diagnoses included borderline personality disorder, obsessive compulsive disorder (OCD), closed head injury, schizophrenia, psychosis, post-traumatic stress disorder (PTSD), and drug-seeking behavior. R2's admission nursing assessment dated January 19, 2025, indicated her diagnoses were hypertension, muscle spasms, anxiety, chronic pain, depression, and heartburn. The nursing assessment indicated R2 had agitation, anxiety, and hoarding. The assessment indicated R2 yelled and insulted staff, and hoarded items in her room. R2's assessment failed to indicate R2's diagnosed personality disorders and mental health diagnoses. The assessment indicated R2 yelled and insulted staff, and hoarded items in her room. The nursing assessment indicated R2 was not at risk to be abused by others.	0 630		

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	37567	A. BUILDING: _____ B. WING _____	C 05/08/2025

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0 630	Continued From page 11 Law enforcement records dated January 1, 2025, through May 7, 2025, indicated R2 called law enforcement 35 times. The records indicated R2 made accusatory statements of rape, physical assault, and theft. Law enforcement made 24 reports from these calls. The records indicated R2 made multiple claims R4 physically assaulted and stole from her. Law enforcement records described R2 as "irate", and her behaviors included "yelling" and "cussing." Examples of some of the incidents R2 reported to law enforcement included: -January 30, 2025, at 4:53 p.m., R2 told law enforcement someone raped her and cut off her head. -February 21, 2025, at 12:40 p.m., R2 yelled at R4, and they used very "colorful" language with each other. -February 22, 2025, at 1:20 p.m., R2 told law enforcement R4 pushed her against a wall. -April 19, 2025, at 3:39 p.m., R2 told law enforcement R4 took pop out of her room, she hit door, then he "threw" her into a chair. R2's progress notes described R2's aggressions toward staff, and other residents, examples included: R2's progress note dated, March 7, 2025, at 8:09 p.m., indicated R2 got into a really big fight with another resident, adding to the ongoing tension that has been building for the past month. R2's progress note dated, March 14, 2025, at 7:42 p.m., indicated R2 frequently yelled and argued with other residents. R2 displayed "aggressive" and "threatening behavior." R2's progress note dated,March 31, 2025, at 8:06	0 630		

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0 630	Continued From page 12 p.m., indicated R2's behavior was increasingly worse, and she often engaged in heated arguments with both staff and residents. The notes indicated R2's conduct caused discomfort for everyone around her. R2's progress note dated, April 2, 2025, at 8:39 a.m., indicated R2 was awake at 1:10 a.m., and yelled at another resident accusing them of stealing. The notes indicated R2 yelled until 4:00 a.m. R2's progress note dated, April 2, 2025, at 6:35 p.m., indicated R2 physically attacked an employee. R2's progress note dated, April 10, 2025, at 8:41 a.m., indicated at 2:45 a.m., R2 screamed and banged on her door nonstop for over an hour. This behavior woke other residents. Progress notes further explained other residents voiced ongoing concerns about the noise and disorder. An email dated March 28, 2025, at 4:10 p.m., from the licensee, to R2's case manager (CM)-E indicated R2 recently purchased a knife. The email indicated R2 struggled with severe sleep deprivation, and frequently screamed thought the night. R2's behavior was increasingly unpredictable and R2 required close monitoring. R2's nursing assessments dated February 4, 2025, and April 18, 2025, contained the same information as R2's admission assessment. The nursing assessments failed accurately reflect R2's behaviors after multiple incidences occurred and assess R2's new behaviors to person centered individualized interventions to manage her susceptibility to abuse, abuse towards other nor self-abuse. Additionally, the assessments	0 630		

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0 630	Continued From page 13 also failed to include R2's accurate diagnoses to assess and manage her baseline personaility disorders and mental health. An email dated May 12, 2025, at 10:44 a.m., from the licensee to CM-E indicated R2 was openly telling staff and others she carried a knife, and her behavior was threatening to everyone at the licensee. R2's clinical record lacked identification R2 obtained a knife, or interventions to minimize the risk of abuse to herself and others. R2's individual abuse prevention plan (IAPP) dated April 18, 2025, indicated R2 had hoarding behavior and agitation. The IAPP indicated R2 yelled and insulted staff. The IAPP indicated R2 argued with other residents and accused them of stealing from her. The IAPP lacked interventions for behavior management. The IAPP inaccurately indicated R2 was not at risk to be abused. The IAPP lacked indication other residents were at risk to be abused by R2. The IAPP failed to identify R2's history of physical violence, and inaccurate accusations towards others. The IAPP failed to identify R2 frequently directed allegations of rape, violence, and theft toward R4. R3 R3 admitted to the licensee for diagnoses including cerebral infarction (stroke), heart disease, hemiparesis, and hemiplegia. R3's service plan dated September 23, 2024, indicated he required behavior management for agitation, anxiety, and visual hallucinations. R3's nursing assessment dated September 24, 2024, indicated he had no behavior concerns and was not at risk to be abused. The nursing	0 630		

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0 630	Continued From page 14 assessment indicated R3 had left sided weakness, and amputation of his left leg. R3's nursing assessment failed to identify R3's was at risk to abuse others. R3's IAPP dated March 24, 2025, indicated R3 had left-sided weakness and amputation of his left leg. The IAPP indicated R3 had visual hallucinations, required anti-psychotic medication and refuses further recommended evaluation for hallucinations. The IAPP failed to identify R3's susceptibility to abuse, risk to abuse others or risk to abuse himself. R4 R4 admitted to licensee for diagnoses including depression, schizophrenia, anxiety, and substance use disorder. R4's service plan dated October 16, 2024, indicated he required behavior management for anxiety and depression. R4's nursing assessment dated April 18, 2025, inaccurately indicated he was not at risk to be abused. The assessment indicated R4 had no behavior concerns. The assessment indicated R4 had anxiety and required breathing exercises. R4's IAPP plan dated April 18, 2025, inaccurately indicated R4 was not at risk to be abused. The IAPP failed to accurately identify interventions to minimize his risk of abuse from R2 who frequently "targeted" him. The IAPP failed to identify if R4 was at risk to abuse others or himself. On April 29, 2025, at 9:32 a.m., R4 said R2 is angry all the time. R4 said R2 had schizophrenia and hears voices in her head. R4 said R2	0 630		

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0 630	Continued From page 15 accused him of stealing. R4 said R2 threatened him with physical violence, but had not assaulted him. R4 said he lived with R2 at a different location prior to admission into the licensee. R4 said he was happy with his current living situation. On April 29, 2025, at 9:49 a.m., house manager (HM)-C said R2 was "high maintenance." R2 called law enforcement frequently and had accused law enforcement officers of rape. HM-C said the licensee checked the video footage and R2's accusations were unfounded. R2 has significant mental health history. On May 9, 2025, at 11:29 a.m., registered nurse (RN)-A said R2 refused to attend medical appointments and R2 does not receive mental health care. RN-A said R2's primary doctor refills R2's medications, and she only takes one mental health medication (Fluoxetine, used for depression). RN-A said R2's behavior included yelling and throwing "stuff". RN-A said the licensee kept R2 away/separate from other residents. RN-A said talking to R2 was really the only solution for managing R2's behavior. RN-A said other interventions for R2's behavior management included getting R2 out for "fresh air" and spending time with her. RN-A said R2 did not show her any bruising. R2 did not tell her she was raped. On May 9, 2025, at 12:04 p.m., licensed assisted living director (LALD)-B said R2 accused multiple people (staff and law enforcement) of rape. LALD-B said R2 also accused R4 of raping her several times. LALD-B said R2 had verbally abused all residents. LALD-B said R2's case manager will not come to the licensee without security or law enforcement with her due to R2's behaviors. LALD-B said the licensee's actions to	0 630		

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0 630	Continued From page 16 protect other residents from R2's behaviors included having staff present all the time. LALD-B said she asked R4 if he wanted to move to a different room, however he declined. LALD-B said R3 and R5 live upstairs, away from R2. LALD-B said she attempted to initiate discharging R2, but R2's case manager told her no other facility would accept her for admission. On May 14, 2025, at 12:18 p.m., RN-A acknowledged IAPP's should be updated with incident, or change in condition. RN-A said the compute generates IAPP's from the nurses nursing assessment. The licensee's policy titled, Vulnerable Adult, dated January 25, 2025, indicated the licensee would individually assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse to that resident. TIME PERIOD TO CORRECT: Seven (7) days	0 630		