Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL399598162M
Compliance #: HL399599043C

Date Concluded: March 20, 2026

Name, Address, and County of Licensee Investigated:
Bimsol Care LLC
5542 Unity Avenue North
Crystal, Minnesota 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, RN
Special Investigator

Finding: Inconclusive

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):
Alleged Perpetrator (AP)-1 and AP-2 neglected the resident when AP-1 and AP-2 failed to call 911 and initiate cardiopulmonary resuscitation (CPR) as soon as possible.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The time between when AP-2 last saw the resident awake and when 911 was called, was approximately 30 minutes. There were conflicting reports on what time the resident became unresponsive. AP-1, AP-2, and other facility staff recounted a similar story and timeline of events. AP-1 contacted the nurse, and AP-2 called 911 and initiated CPR.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record, death record, hospital records, facility

incident report, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed medication administration.

The resident resided in an assisted living facility. The resident's diagnoses included quadriparesis. The resident's service plan included assistance with medication administration and repositioning. The resident's assessment identified his code status as CPR.

An incident report, completed by AP-2, indicated AP-1 reported to AP-2, the resident spilled medications from his mouth. When assessed over video, the resident had still been conscious. AP-2 told AP-1 he would come to the facility to assess the resident. When AP-2 arrived fifteen minutes later, he met AP-1 and found the resident unconscious. AP-2 called 911. AP-1 and AP-2 moved the resident from the bed to the floor. They performed CPR until law enforcement arrived and continued CPR until the paramedics arrived to take over.

A law enforcement report indicated law enforcement arrived at the facility and went to the lower level where AP-2 had been performing chest compressions on the resident. AP-1 had also been in the resident's room upon law enforcement's arrival. The resident had white and red foam like discharge coming from his mouth. His skin felt warm, but law enforcement could not find a pulse. A law enforcement officer took over chest compressions and asked AP-2 how long the resident had been like this. AP-2 told him it had been five minutes. The officer asked AP-2 about the resident's medical history, but AP-2 could not answer. AP-2 stated he found the resident on the bed and had been instructed to move him to the floor and begin CPR. The paramedics and the fire department arrived on scene and took over. The resident eventually regained a pulse. The paramedics transported him to the hospital. The officers attempted to speak with AP-1 and AP-2 about the resident and found inconsistencies in their stories about how long the resident had been in that state. AP-1's and AP-2's stories were confusing and kept changing. An officer observed AP-1's call log which showed he placed a call to AP-2 at 10:06 p.m., and again at 10:13 p.m. AP-2 stated he did not receive a call at 10:06 p.m., even though the log showed it was a one-minute call. The call at 10:13 p.m. was 41 seconds long. AP-1 placed three other calls to one other person around 10:30 p.m., but the officer did not know whose number it was. AP-2 stated when he received the call at 10:13 p.m., he asked to be placed on a video call. He saw the resident was okay but had been told he spit up her medications. AP-2 told AP-1 he was on his way to the facility. AP-2 did not know the exact time he arrived at the facility but stated it took 14 minutes to arrive. Additionally, AP-1 and AP-2 did not have the resident's face sheet printed out and were unable to print it. AP-1 told an officer he gave the resident his medications, went to give another resident on the same level of the facility their medications, then went back to check on the resident. AP-1 saw the resident had spit up liquid, which was when he called AP-2 for the second time. AP-1 stated the resident never went unconscious before AP-2 arrived. The report indicated it was unclear as to why there seemed to be about a 15 minute gap between AP-2 arriving at the house and when 911 was called, at 10:43 p.m.

The hospital record indicated the resident's normal heartbeat and blood flow returned after the cardiac arrest. The resident remained unresponsive and was intubated. A physical examination showed loss of brainstem function. The resident was moved to comfort cares and died less than twenty-four hours after the incident. The hospital record indicated that although emergency medical services initially reported the resident had been down for three minutes before being found, a physician suspected the resident had likely been down longer and hypoxic (lack of adequate oxygen in the body) for a significant period of time.

The resident's death record identified the resident's cause of death as damage to the brain caused by complete lack of oxygen to the brain, due to respiratory and cardiac arrest (the sudden and unexpected stopping of the heart's function).

During an interview, nurse-1 stated she missed a call from AP-1. She called AP-1 back who informed her he noticed something resembling medication in the resident's mouth. Nurse-1 instructed AP-1 to change their phone call to a video call and asked AP-1 to help with counting respirations. Nurse-1 stated at that time, the resident continued to open his eyes, remain alert, and appeared fine. There did not appear to be a need for AP-1 to call 911 at that time. Because the resident appeared okay and she knew AP-2 had been on his way to the facility, nurse-1 instructed AP-1 to clear anything from the mouth. Nurse-1 stated she went to the facility and joined AP-2 while he tried printing out documents to send to the hospital.

During an interview, AP-1 stated he gave the resident his medications. AP-1 came back into the room and saw the resident spitting out liquid. AP-1 called nurse-1 who did not answer. AP-1 then called AP-2 and informed him the resident had been spitting out liquid. AP-2 stated he would come to the facility. Nurse-1 called back and conducted a video call with resident. AP-1 stated the resident had been blinking but did not say anything after the call. When AP-2 arrived, the resident's eyes were open. AP-1 and AP-2 put the resident on the floor, and AP-2 called 911.

During an interview, AP-2 stated he received a call but could not remember what time. AP-1 informed him the resident saw something like reddish medication coming out of his mouth. AP-1 verified the head of the bed had been elevated. AP-2 started driving over to the facility. About ten minutes later, AP-2 arrived and went down into the resident's room. AP-2 tapped the resident and asked how he was doing, but the resident did not answer. AP-2 called 911, they put the resident on the floor, then performed CPR until law enforcement arrived. AP-2 tried looking for requested paperwork for law enforcement but could not find it. He eventually printed out paperwork and provided it to law enforcement.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No. The resident is deceased.
Family/Responsible Party interviewed: No. The resident had no family listed.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Facility staff called 911 and started chest compressions.

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
	39959	A. BUILDING: _____ B. WING _____	C 01/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIMSOL HOME CARE LLC	5542 UNITY AVENUE NORTH CRYSTAL, 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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction order is 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: HL399599043C/HL399598162M On January 26, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 4 residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL399599043C/HL399598162M, tag identification 1760.	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.	
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 1 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 staff documented medication administration for four of four residents (R1, R2, R3, R4) 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 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: R1 R1 admitted to the licensee February 14, 2025. R1's diagnoses included heart failure. R1's service plan dated November 1, 2025, indicated R1 received assistance medication administration. R1's assessment dated October	01760		

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01760	Continued From page 2 24, 2025, indicated R1 needed help taking his medications. R1's medication administration record (MAR) dated November 2025, indicated orders included: Atorvastatin calcium 40 milligrams (mg) by mouth once daily at 5:00 p.m. Baclofen 20 mg by mouth four times daily at 8:00 a.m., 12:00 p.m., 5:00 p.m., and 8:00 p.m. Escitalopram oxalate 20 mg by mouth at bedtime at 8:00 p.m. Gabapentin 40 mg by mouth three times daily at 8:00 a.m., 2:00 p.m., and 8:00 p.m. Ipratropium bromide and albuterol sulfate 2.5-0.5 mg inhale 3 ml via a nebulizer four times daily at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. levothyroxine 50 micrograms (mcg) by mouth once daily at 8:00 p.m. Melatonin 6 mg by mouth at bedtime at 8:00 p.m. Midodrine HCl 15 mg by mouth three times daily 8:00 a.m., 2:00 p.m., and 8:00 p.m. Mupirocin 2% topically to affected areas two times daily at 8:00 a.m. and 8:00 p.m. Olanzapine 2.5 mg by mouth two times daily at 8:00 a.m. and 8:00 p.m. Seroquel 25 mg by mouth three times daily at 8:00 a.m., 2:00 p.m., and 8:00 p.m. Seroquel 150 mg by mouth at bedtime at 8:00 p.m. Tizanidine 4 mg by mouth at bedtime at 8:00 p.m. R1's MAR dated November 2025, indicated facility staff failed to chart medication administration for the following medications from November 1, 2025, to his hospitalization November 16, 2025: -Atorvastatin calcium 40 mg - seven times at 5:00 p.m. -Baclofen 20 mg - three times at 12:00 p.m.,	01760		

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01760	Continued From page 3 seven times at 5:00 p.m., and eleven times at 8:00 p.m. -Escitalopram oxalate 20 mg - eleven times at 8:00 p.m. -Gabapentin 40 mg at 2:00 p.m., and eleven times at 8:00 p.m. -Ipratropium bromide and albuterol sulfate 2.5-0.5 mg inhale 3 ml at 12:00 p.m., six times at 4:00 p.m., and eleven times at 8:00 p.m. -Levothyroxine 50 mcg - eleven times at 8:00 p.m. -Melatonin 6 mg - eleven times at 8:00 p.m. -Midodrine HCl 15 mg - three times at 2:00 p.m., and eleven times 8:00 p.m. -Mupirocin 2% topically - eleven times at 8:00 p.m. -Olanzapine 2.5 mg - eleven times at 8:00 p.m. -Seroquel 25 mg - three times at 2:00 p.m., and eleven times at 8:00 p.m. -Seroquel 150 mg - eleven times at 8:00 p.m. -Tizanidine 4 mg - eleven times at 8:00 p.m. R2 R2 admitted to the licensee April 5, 2024. R2's diagnoses included heart failure. R2's service plan dated January 26, 2026, indicated R2 received assistance with medication administration. R2's assessment dated December 4, 2025, indicated staff would administer all medications as ordered by the provider and document refusals. R2's MAR dated January 2026, indicated orders included: Baclofen 10 mg by mouth four times daily at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. Cimetidine 200 mg by mouth at bedtime at 9:00 p.m. Levetiracetam 500 mg by mouth twice daily at 9:00 a.m. and 9:00 p.m.	01760		

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01760	Continued From page 4 Melatonin 5 mg by mouth at bedtime at 9:00 p.m. Mirtazapine 30 mg by mouth at bedtime at 9:00 p.m. R2's MAR dated January 2026, indicated facility staff failed to document medication administration for the following medications from January 1, 2026, to January 27, 2026: -Baclofen 10 mg - two times at 1:00 p.m., nine times at 5:00 p.m., and twenty times at 9:00 p.m. -Cimetidine 200 mg - twenty times at 9:00 p.m. -Levetiracetam 500 mg - twenty times at 9:00 p.m. -Melatonin 5 mg by mouth at bedtime - twenty times at 9:00 p.m. -Mirtazapine 30 mg by mouth at bedtime - twenty times at 9:00 p.m. R3 R3 admitted to the licensee July 19, 2023. R3's diagnoses included Grave's disease. R3's service plan dated January 26, 2026, indicated R3 received assistance with medication administration. R3's assessment dated December 26, 2025, indicated R3 needed help taking his medications. R3's MAR dated January 2026, indicated orders included: Potassium Chloride ER 20 milliequivalents (mEq) by mouth twice daily at 8:00 a.m. and 8:00 p.m. R3's MAR dated January 2026, indicated facility staff failed to document medication administration for the following medications from January 1, 2026, to January 27, 2026: -Potassium Chloride ER 20 mEq - seventeen times at 8:00 p.m.	01760		

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01760	Continued From page 5 R4 R4 admitted to the licensee July 14, 2023. R4's diagnoses included acute respiratory failure. R4's service plan dated January 6, 2026, indicated R4 received assistance with medication administration. R4's assessment dated January 6, 2026, indicated R4 needed help taking his medications. R4's MAR dated January 2026, indicated orders included: Atorvastatin calcium 20 mg by mouth at bedtime at 8:00 p.m. Carvedilol 6.25 mg by mouth twice daily at 8:00 a.m. and 8:00 p.m. Apixaban 5 mg by mouth twice daily at 8:00 a.m. and 8:00 p.m. Furosemide 20 mg by mouth twice daily at 8:00 a.m. and 8:00 p.m. Gabapentin 300 mg by mouth three times daily at 8:00 a.m., 3:00 p.m., and 8:00 p.m. Insulin Aspart 100 units per milliliter (mL) inject 5 units subcutaneously three times daily before meals at 8:00 a.m., 1:00 p.m., and 5:00 p.m. Melatonin 3 mg by mouth at bedtime at 8:00 p.m. Mirtazapine 7.5 mg by mouth at bedtime at 8:00 p.m. Risperidone 2 mg by mouth daily at 8:00 p.m. R4's MAR dated January 2026, indicated facility staff failed to document medication administration for the following medications from January 1, 2026, to January 27, 2026: -Atorvastatin calcium 20 mg - ten times at 8:00 p.m. -Carvedilol 6.25 mg - ten times at 8:00 p.m. -Apixaban 5 mg - ten times at 8:00 p.m. -Furosemide 20 mg at - ten times 8:00 p.m.	01760		

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01760	Continued From page 6 -Gabapentin 300 mg - three times at 3:00 p.m., and ten times 8:00 p.m. -Insulin Aspart 100 units per mL 5 units - three times at 1:00 p.m., and six times at 5:00 p.m. -Melatonin 3 mg - ten times at 8:00 p.m. -Mirtazapine 7.5 mg - ten times at 8:00 p.m. -Risperidone 2 mg - ten times at 8:00 p.m. During an interview January 26, 2026, at 1:43 p.m., registered nurse (RN)-B stated in November, there were some issues with RTasks (electronic medical record), with items not showing up on the overnight shift. During an interview January 26, 2026, at 1:44 p.m., director of nursing (DON)-A stated staff were supposed to print out paper MARs and initial on there to document medication administration, but they did not. At 2:02 p.m., DON-A stated the overnight shift currently continued to not document medication administration. The licensee-provided policy Documentation of Medication Administration, undated, indicated each medication administered would be documented in the resident's record. The policy indicated staff would document each medication administration immediately after that task had been performed. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		