Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL358841744M
Compliance #: HL358842929C

Date Concluded: May 16, 2025

Name, Address, and County of Licensee Investigated:
Comfort Care Assisted Living
414 E 26th St 1
Minneapolis, MN 55404
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, 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 facility staff neglected the resident when the resident refused mental health medications and put a kitchen knife to a staff member's throat. Additionally, the facility abused the resident when staff spit on the resident and kicked her.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse and neglect were not substantiated. The facility assessed the resident for areas of vulnerability and implemented interventions to address the resident's behaviors. Although physical abuse and neglect were reported, there was no corroborating evidence to support abuse or neglect occurred. The facility was aware of the concerns with the resident and discussed the concerns with the resident's respective care teams.

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

worker. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, law enforcement reports, and related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder and cannabis hyperemesis syndrome concurrent related to cannabis abuse. The resident's service plan included assistance with behavior and medication management. The resident's assessment indicated the resident had a history of aggressive behavior and was independent with decision making.

Documentation indicated the day of the incident facility staff was attempting to administer the resident's medications when the resident became verbally aggressive towards staff. The resident then struck a facility staff member with a broom. Later, when facility staff attempted to do the dishes, the resident came up from behind and held a kitchen knife to the facility staff's throat. Facility staff called the resident's family member and 911.

Medical records indicated in the months prior to the incident the resident was taking her mental health medications; however, the resident had been in and out of the hospital related to excessive vomiting. Medical records indicated the psychiatrist noted the resident did better with higher doses of mediations but the resident declined to take certain medications or to increase doses of medications. The psychiatrist noted she told the resident to "behave herself in terms of her interactions with nursing staff." The resident's medical record lacked evidence that facility staff abused the resident.

During an interview, facility staff stated the resident exhibited behaviors however the staff were trained with interventions on how to deescalate and if interventions were not effective the facility staff would notify the nurse.

During an interview, the facility nurse stated the resident was sweet but could switch to verbal aggression quickly. However, staff were trained on interventions for the resident to deescalate her behaviors. The facility nurse stated any time the resident exhibited behaviors her medical team was updated. However, the resident was her own person and would call the provider and get her mental health medications decreased or changed.

During an interview, facility management stated the resident was interviewed, staff were interviewed, and the resident's physician, psychiatrist, and case manager were updated regarding the incident. The facility conducted a meeting regarding finding alternate placement for the resident regarding her behaviors.

During an interview, a mental health case manager stated she had no concerns with the care the resident received at the facility.

During an interview, the resident did not report concerns of neglect or abuse.

In conclusion, the Minnesota Department of Health determined neglect 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:
(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.

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: Yes.
Family/Responsible Party interviewed: No. Attempts made to interview family member #2 were not successful.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility investigated, contacted the police, and updated the resident’s care team.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35884	A. BUILDING: _____ B. WING _____	C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE ASSISTED LIVING	414 EAST 26TH STREET MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments On April 16, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL358842929C /#HL358841744M No correction orders are issued.	0 000		