STATE LICENSING COMPLIANCE REPORT

Report #: #HL307561187C

Date Concluded:

Name, Address, and County of Facility Investigated:
St. John Home Care LLC
1502 Archwood Road
Minnetonka, MN 55305
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30756	A. BUILDING: _____ B. WING _____	C 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	1502 ARCHWOOD ROAD MINNETONKA, MN 55305

(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: #HL307561187C #HL307568007C/#HL307564142M On September 24, 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 five residents receiving services under the provider's Assisted Living license. The following correction orders are issued for ##HL307568007C/#HL307564142M, tag identification 0250, 0620, 0630, 2310, and 2360.	0 000		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	0 250		

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0 250	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or staff of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or staff; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	0 250		

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0 250	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure representatives of the Minnesota Department of Health (MDH) had access to resident records and facility documents to review for a complaint investigation. 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), and was 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: On September 24, 2025, at the investigator arrived to the facility and observed furniture in large bags scattered throughout the yard.	0 250	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	

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0 250	Continued From page 3 The investigator sent an email to licensed assisted living director (LALD)/registered nurse (RN)-E dated November 7, 2024, at 5:41 p.m., requested records for a complaint investigation to be emailed by October 2, 2025, at 12:00 p.m., including: Facility records - Notice of closure to MDH of the facility- - List of residents at closure and where the resident discharged to - Staff list with contact information (telephone number and email address) - Policies: Vulnerable adult, individual abuse prevention plan, discharge, - Contract - UDALSA Medical Records for R1 - Face sheet/Demographic Page - Signed service plan - Nursing notes/Progress notes - Assessment- last assessment - Individual Abuse Prevention Plan - Service Delivery Record/point of care documentation - MAR/TAR- last two months - Incident Report/Complaint/Grievance/Concerns - Physician visits - Discharge summary On October 2, 2025, at 8:39 p.m., the investigator sent an email to follow up and ensure the documents would be emailed by today at 12:00 p.m. On October 2, 2025, at 11:28 a.m., LALD/RN-E sent an email that included two of the licensee's	0 250	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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0 250	Continued From page 4 staff contact information and information regarding the facilities property damage and temporary closure. On October 2, 2025, at 11:44 a.m., the investigator sent an email to LALD/RN-E asking if rest of the requested documents would be emailed today. On October 2, 2025, at 12:07 p.m., LALD/RN-E emailed the UDALSA. On October 7, 2025, at 7:10 p.m., the investigator sent an email to LALD/RN-E requesting the following documents that had not been emailed. Facility information requested: - Name or resident that was moved and notification to guardian/case manager- - Resident list as of June - Notification to MDH of notification that no residents resided at the licensee and the plan with the receiving facility. - Policies: Vulnerable adult, individual abuse prevention plan, discharge, - Contract - Contact information for R2. Medical Records for R1 - Signed service plan - Nursing notes/Progress notes- - Assessment- last assessment - Individual Abuse Prevention Plan - Service Delivery Record/point of care documentation - Medication administration record (MAR)/ treatment administration record (TAR) - Physician visits from May to current - all incident reports, Minnesota adult abuse	0 250		

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0 250	Continued From page 5 reporting center (MAARC) reports, police report, and internal investigations. On October 8, 2025, at 10:31 a.m., LALD/RN-E sent an email to the investigator indicating the licensee could not provide documents for the last two month as R1 had moved out more than two months ago. LALD/RN-E stated she did not have access to the signed service plan, assessment, individual abuse prevention plan from where she was and would be back in the office October 10, 2025, and she would send the documents October 13, 2025. On October 8, 2025, at 4:38 p.m., the investigator emailed LALD/RN-E indicating the documents were requested on September 30, 2025, which was over one week ago. The email indicated when the last two months of progress notes were requested meant the last two months the resident resided at the facility. The investigator also questioned if there was only one incident report and no police reports for R1 and if so, requested those documents be emailed. On October 13, 2025, from 3:52 p.m., LALD/RN-E sent an employee list and '1's IAPP. At 3:54 p.m., sent R1's UDALSA. At 3:57 p.m., sent R1's care plan. At 4:16 p.m., sent R1's service plan On October 24, 2025, at 7:16 p.m., the investigator emailed LALD/RN-E indicating while conducting the investigation it appeared there were other vulnerable adults involved and requested the following information by October 28, 2025, 1:00 p.m., for R2 and R3. - Signed service plan	0 250		

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0 250	Continued From page 6 - Nursing notes/Progress notes - Assessment- last assessment - Individual Abuse Prevention Plan Current- - Service Delivery Record/point of care documentation On October 28, 2025, at 2:05 p.m., the investigator emailed LALD/RN-E again requesting R2, and R3's records and requested the records the sent by October 29, 2025, at 1:00 p.m. On November 6, 2025, at 10:01 a.m., the investigator emailed LALD/RN-E indicated the additional records for R2 and R3 had been requested twice, with no response. The email also indicated on November 5, 2025, the investigator also emailed LALD/RN-E requesting a phone interview for the maltreatment investigation that was being conducted. The email indicated LALD/RN-E should respond to the email with availability for a phone interview by November 7, 2025, or a subpoena would be sent. On November 6, 2025, at 11:16 a.m., LALD/RN-E sent and email indicating she was declining the interview as she had that right. The email stated based on her past experience with the investigator, she did not think this would be a fair process and that the investigator may have already concluded on the decision. LALD/RN-E also requested a reason why the investigation was being conducted and requested my supervisors information. At the time of this report the following information had not been received by the licensee: - Name or resident that was moved due to the	0 250		

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0 250	Continued From page 7 temporary closure and notification to guardian/case manager- - Resident list as of June - Notification to MDH of notification that no residents resided at the licensee and the plan with the receiving facility. - Policies: Vulnerable adult, individual abuse prevention plan, discharge, - Contract - Contact information for R2. - R1's medication administration record (MAR)/ treatment administration record (TAR) Medical records for R2, R3 - Signed service plan - Nursing notes/Progress notes - Assessment- last assessment - Individual Abuse Prevention Plan Current- - Service Delivery Record/point of care documentation No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 250		
0 620 SS=F	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to	0 620		

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0 620	Continued From page 8 believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the	0 620		

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0 620	Continued From page 9 reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to immediately report resident to resident physical violence for three of three residents (R1, R2, and R3). Staff observed multiple incidents of resident to resident altercations threats and failed to report any of the incidents to the common entry point Minnesota Adult Abuse Reporting Center (MAARC). The licensee also failed to thoroughly investigate the incident or take action to protect residents or staff. This had the potential to cause harm to all five residents that were residing at the facility. 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). Findings include: R1 was admitted on November 26, 2024, with diagnoses including schizophrenia, post-traumatic stress disorder, and anxiety.	0 620		

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0 620	Continued From page 10 R1's service plan dated November 1, 2024, indicated R1 received assistance with dressing, bathing, grooming, medication administration. The plan also included managing anxiety, self-injurious behaviors, verbal aggression, physical aggression, property destruction, and mental health needs. R1's 90-day assessment dated May 24, 2025, indicated R1 was alert and oriented to person, place, time, and situation. R1 was resistive to cares, and medications. R1 had verbal and physical aggression, hostility, defiance, and self-harm. The assessment did not include pharmacological or non-pharmacological interventions. R1's individual abuse prevention plan (IAPP) dated May 24, 2025, indicated R1 was susceptible to abuse from another individuals, including other vulnerable adults. R1 would start fights with staff and other residents. The intervention indicated staff should monitor for signs and symptoms of abuse or neglect from others and report to nurse promptly. R1 also was at risk of abusing other vulnerable adults and liked to start fights with other residents. Staff would intervene and prevent physical violence from occurring by removing the other resident or distracting R1. The intervention indicated staff should monitor R1's behavior and intervene with any actions of abuse toward others. R1 had some identified areas of potential vulnerability, but no signs of abuse or neglect. The plan indicated the interventions were listed on the service plan/care plan. R1's care plan record from June 1 to June 30,	0 620		

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0 620	Continued From page 11 2025, indicated if R1 displayed physical violence staff should discuss with R1 alternative ways of expressing emotion and releasing physical energy or tension. R1 needs to learn non-destructive ways to express feelings and release tension. Encourage R1 to increase their physical activity to release tension and plan to continue a regular exercise regimen. Encourage solitary or non-competitive activities to avoid placing R1 in a competitive situation. The manage property destruction tell R1 destroying property was not acceptable. Be clear in the expectations and what the consequences will be if R1 destroys property. Be very clear that frustration is not an excuse for destroying property. Be aware of factors that increase the likelihood of property destruction in R1. Try to help R1 express their feelings in a non-destructive way. The care plan did not identify updated interventions regarding R1's physical violence and property destruction. R1's medical record included the following documentation: March 22, 2025, at 12:23 a.m., R1 and R2 got into an argument. R1 left to cool down but R2 followed, they got into an argument and then the staff heard a loud bang and saw R1 and R2 fighting and staff separated them. Staff told R1 to go upstairs. When R1 went upstairs he broke the window. R1's medical record did not include an incident report or a MAARC report for the resident to resident altercation. March 27, 2025, at 6:34 a.m., R3 came home from work, and said R1 broke something in his	0 620		

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0 620	Continued From page 12 room. R1 heard R3 say that and R1 came upstairs to fight R3. The staff stopped R1, but R1 went upstairs and punched the walls. April 3, 2025, at 10:32 p.m., R1 and R2 threatened to murder R3. County workers were invited to talk to R1 and R2. The staff showed the health workers violent videos of R1 and R2 fighting and breaking things in the house. The health workers did not take any action. When they left they called and told the nurse to call the police. There was no police report record dated April 3, 2025. R1's medical record did not include an incident report or MAARC report. Police records indicated a police report was not made. May 8, 2025, at 9:53 a.m., R1 forcibly entered another resident's room and took his television. R1 broke the televisions in his apartment and the living room and decided to take another resident's television. R1 attempted to hit staff when the staff tried to stop him. R1's medical record did not include an incident report or MAARC report. Police records indicated a police report was not made. June 1, 2025, at 2:56 p.m., R1 was very angry and planning to break all the windows in the house because he could not get a ride to see his mom. R1 brought a hammer upstairs and broke a little part of the wall by the kitchen. June 2, 2025, at 9:32 a.m., R1 and R2 forcefully broke into another resident's room and took another client's belongings, dresses, and items.	0 620		

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0 620	Continued From page 13 R1's medical record did not include an incident report or MAARC report. Police records indicated a police report was not made. June 4, 2025, at 8:20 a.m., R3 went to R1 and R2's room requesting the money that was owed and R1 attacked R3. Staff heard the commotion, rushed to the apartment and broke up the fight. A few hours later R1 and R2 went to R3's room with the intention of beating him up and threatened to kill him if he ever went into their room. To prevent further interaction between them, the facility decided to pay R3 the money that was owed to him. R1's medical record did not include an incident report or MAARC report. Police records indicated a police report was not made. June 9, 2025, at 9:41 a.m., Staff heard a lot of noise and shouting in R1 and R2's room and R2 was yelling that they were going to call the police. Staff rushed downstairs and R1 had R2 pinned down on the couch and was hitting them with his fists. Staff separated them, but the commotion continued. R1 continued to try and hit R1, the staff told R1 he was going to call the police if the fighting continued. R1 threw something at the staff and R2 went outside. The staff was standing at the entrance, R1 came from behind and punched the staff on the neck and head. The incident occurred between 7:10 a.m., to 7:20 a.m. R1's medical record did not include an incident report or MAARC report. Police records indicated a police report was not made. June 12, 2025, at 2:19 p.m., 2:19 p.m., R1 was	0 620		

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	30756	A. BUILDING: _____ B. WING _____	C 09/24/2025

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0 620	Continued From page 14 taken to the hospital by the authorities because of his violent behavior, physical assault on staff, threatening to beat up other residents. R1 usually blames his behavior on mental health issues. Therefore, after assault on staff (punches to staff head, and neck, breaking the last windows), his case worker and the facility called the police to take him to the hospital for his violent behavior. Police records dated June 12, 2025, at 10:35 a.m., indicated R1 was breaking windows and threatening to kill other residents. R1 also assaulted a staff member recently. R1 broke out all of the windows in the home and R1 usually carried a knife with him. R1 was transported to the hospital and placed on a hold. R1's medical record did not include an incident report or MAARC report. July 12, 2025, at 1:35 p.m., R1 and R2 got in a fight this afternoon. R2 accused R1's mother of taking more than $150.00 from her, she got angry, and they both started shouting and insulting one another. Staff tried to stop them. R2 attacked R1 and he got hurt and was bleeding from his mouth and nose. Staff separated them and R1 went to his room. At 1:40 p.m., R2 left the house because they were afraid staff was going to call the police even though staff assured them they would not. R1's medical record did not include an incident report or a MAARC report. Police records indicated a police report was not made. August 1, 2025, 1:58 p.m., R1 and R2 moved out of the facility today by 2:00 p.m. Staff assisted packing belonging and gave them their	0 620		

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0 620	Continued From page 15 medications. R2 and R3's medical records were requested, but not provided. On October 24, 2025, at 1:30 p.m., case manager (CM)-A stated the registered nurse (RN)/licensed assisted living director (LALD)-E told her she did not call the police because the police would not do anything and usually made the situation more unsafe after they left. RN/LALD-E called CM-A and requested a meeting on June 12, 2025, due to R1's increased behaviors. and reported R1 was walking around with a knife, and had assaulted staff and residents and threatened to kill the residents. CM-A stated she contacted the police and encouraged RN/LALD-E to not accept R1 back after hospitalization due to the concern for the other residents residing at the facility. On October 24, 2025, at 1:30 p.m., CM-B stated she had not received emails from the facility prior to June 2024, regarding R1's increase in behaviors and then all of a sudden in June the licensee wanted to terminate services. CM-B had not been aware R1 had assaulted staff and other residents. CM-B stated after R1 was hospitalized in June, he returned to the licensee. The licensee did not notify her R1 had returned. On October 28, 2025, at 3:00 p.m., unlicensed personnel, (ULP)-C stated R1 would threaten staff and residents and tell them he would kill they came in his room. . ULP-C stated on one occasion he heard R2 shouting and saw R1 standing over and hitting R2. ULP-C stated he got in between them and called RN/LALD-E. ULP-C stated after that incident R1 came from	0 620		

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0 620	Continued From page 16 behind and hit him in the head and neck. ULP-C had also witnessed R2 hit R1. ULP-C stated if the residents were fighting the staff were directed to separate the residents and then call the LALD. ULP-C did call the police once, but they didn't do anything. ULP-C stated he had not been directed to make a report to MAARC. On November 5, 2025, at 1:30 p.m., ULP-D stated he had witnessed R2 lying on the ground and R1 punching them. ULP-D separated R1 and R2, and then R1 went upstairs and broke the window. ULP-D called the nurse, and the nurse calmed them down. ULP-D stated R1 would also become angry and would destroy property. ULP-D stated they were trained to separate the residents and take the aggressive one away and then were to call the LALD/RN and write and incident report. ULP-D stated he didn't call the cops or file a vulnerable adult report. ULP-D stated the incident was documented in the resident's progress note or an incident report. ULP-D stated he had not been directed to make a report to MAARC. On November 6, 2025, at 10:52 a.m., an email sent from LALD/RN-E indicated she declined to be interviewed. A policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 17 (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 facility failed to update the individual abuse prevention plan (IAPP) after resident to resident altercations, physical violence and property destruction for one of one resident (R1). This had the potential to harm all residents residing at that facility. 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: R1 was admitted on November 26, 2024, with diagnoses including schizophrenia, post-traumatic stress disorder, and anxiety. R1's service plan dated November 1, 2024,	0 630		

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0 630	Continued From page 18 indicated R1 received assistance with dressing, bathing, grooming, medication administration. The plan also included managing anxiety, self-injurious behaviors, verbal aggression, physical aggression, property destruction, and mental health needs. R1's care plan record from June 1 to June 30, 2025, indicated if R1 displayed physical violence staff should discuss with R1 alternative ways of expressing emotion and releasing physical energy or tension. R1 needed to learn non-destructive ways to express feelings and release tension. Encourage R1 to increase their physical activity to release tension and plan to continue a regular exercise regimen. Encourage solitary or non-competitive activities to avoid placing R1 in a competitive situation. The care plan record indicated to manage property destruction tell R1 destroying property was not acceptable. Be clear in the expectations and what the consequences will be if R1 destroys property. Be very clear that frustration is not an excuse for destroying property. Be aware of factors that increase the likelihood of property destruction in R1. Try to help R1 express their feelings in a non-destructive way. The care plan did not identify updated interventions regarding R1's physical violence and property destruction. R1's 90-day assessment dated May 24, 2025, indicated R1 was alert and oriented to person, place, time, and situation. R1 was resistive to cares, and medications. R1 had verbal and physical aggression, hostility, defiance, and self-harm. The assessment did not include pharmacological or non-pharmacological interventions.	0 630		

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0 630	Continued From page 19 R1's IAPP dated May 24, 2025, indicated R1 was susceptible to abuse from another individuals, including other vulnerable adults. R1 would start fights with staff and other residents. The intervention indicated staff should monitor for signs and symptoms of abuse or neglect from others and report to nurse promptly. R1 also was at risk of abusing other vulnerable adults and liked to start fights with other residents. Staff would intervene and prevent physical violence from occurring by removing the other resident or distracting R1. The intervention indicated staff should monitor R1's behavior and intervene with any actions of abuse toward others. R1 had some identified areas of potential vulnerability, but no signs of abuse or neglect. The plan indicated the interventions were listed on the service plan/care plan. The licensee's incident report dated January 3, 2025, at 10:14 a.m., indicated R1 became violent and broke furniture and threw a table at staff. R1's medical record did not include any other incident reports. The licensee did not provide other incident reports. R1's progress notes included: January 3, 2025, at 12:22 p.m., an email sent to R1's case managers indicated a serious incident occurred earlier today at the facility when R1's partner (R2) wanted to take the coffee maker to their room. Staff explained the coffee maker was for everyone. After that R1 became extremely agitated and approached staff using profanity and displayed aggressive behavior. R1 attempted to strike staff with a piece of furniture. R1 broke furniture, threw tables, and destroyed the coffee maker. R1 also threatened to	0 630		

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0 630	Continued From page 20 physically harm staff members making the staff feel unsafe. Police records dated January 3, 2025, at 8:07 a.m., indicated a staff member called 911 and reported R1 was trying to attack the staff and other in the house. R1 did not have a weapon but was throwing things at the staff. R1 was upset about a coffee maker. At 8:33 a.m., police records indicated R1 was in his room and calm and did not need the police to intervene. R1's medical record lacked additional interventions to prevent future incidents. March 22, 2025, at 12:23 a.m., R1 and R2 got into an argument. R1 left to cool down but R2 followed, they got into an argument and then the staff heard a loud bang and saw R1 and R2 were fighting and staff separated them. Staff told R1 to go upstairs. When R1 went upstairs he broke the window. R1's medical record lacked additional interventions to prevent future incidents. March 26, 2025, at 8:34 p.m., R1 went to another client's room and broke the television off the wall and broke other furniture. Staff tried to talk to R1, but he refused to listen. Staff attempted to administer medications but R1 refused. R1 has fought R2. R1 has broken windows, walls and televisions. March 27, 2025, at 11:29 a.m., R1 and R2 came back yesterday and R1 went into another resident's room and broke his 65 inch television and destroyed all the property in his room. R1 and R2 owed R3 $400.00, and when R1 and R2	0 630		

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0 630	Continued From page 21 found their gaming system was missing and they assumed R3 took it since they owed R3 money. R2 encouraged R1 to engage in violent behaviors and manipulates R1 easily. R2 will attack R1 and then R2 will scream that R1 is attacking R2. R1 has also destroyed numerous 70-inch televisions in the living room and punched numerous holes in the wall again. The property destruction hours can not cover all the property destruction, and the facility needed to be reimbursed for the destruction. Some days R1 refused medications, destroyed property and get physically violent. It appeared R1 was using illegal drugs but has never been witnessed. If R2 tells R1 to become violent R1 will do it. This was an email sent to R1's county case manager. R1's medical record lacked additional interventions to prevent future incidents. March 28, 2025, at 12:16 p.m., staff called R1's provider and explained R1's behaviors including R1 and R2's fight. The staff also informed the provider of the property damage. A referral will be made for a psychiatrist. R1's medical record lacked additional interventions to prevent future incidents. R1's medical record did not include follow up documentation regarding a psychiatrist appointment. April 3, 2025, at 10:32 p.m., R1 and R2 threatened to murder R3. County workers were invited to talk to R1 and R2. The staff showed the health workers violent videos of R1 and R2 fighting and breaking things in the house. The health workers did not take any action. When they left they called and told the nurse to call the	0 630		

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0 630	Continued From page 22 police. There was no police report record dated April 3, 2025. R1's medical record lacked additional interventions to prevent future incidents. The medical record or facility documents also did not a police report as suggested by the county case workers. April 25, 2025, at 1:23 p.m., R1 and R2 usually threaten to beat up staff. R2 asked for milk and the staff called the supervisor to send supplies, while on the phone R2 attempted to forcefully open another apartment to take the client's supplies. Staff intervened and stopped R2. R2 then told R1 to attack the staff. May 8, 2025, at 9:53 a.m., R1 forcibly entered another resident's room and took the television. R1 broke the televisions in his apartment and the living room and decided to take another resident's television. R1 attempted to hit staff when the staff tried to stop him. May 13, 2025, at 9:09 a.m., R1 broke the downstairs living room television because he did not like the food items in the facilities supply room. R1 and R2 threatened to beat up staff. Staff called the licensed assisted living director (LALD)/registered nurse (RN) to inform her of the concerns. After a few minutes R1 became angry and started breaking the windows, and televisions in the facility. R1's medical record lacked additional interventions to prevent future incidents. June 1, 2025, at 2:56 p.m., R1 was very angry and planning to break all the windows in the	0 630		

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0 630	Continued From page 23 house because he could not get a ride to see his mom. R1 brought a hammer upstairs and broke a little part of the wall by the kitchen. R1's medical record lacked additional interventions to prevent future incidents. June 2, 2025, at 9:32 a.m., R1 and R2 forcefully broke into another resident's room and took another client's belongings, dresses, and items. June 4, 2025, at 8:20 a.m., R1 threatened to beat up and kill R3 when R3 requested his money back that R1 and R2 owed him. According to the facility investigation, R1 and R2 asked R3 to use his online account to purchase items and they were going to repay him with interest. R3 agreed and let R1 and R2 use his account to buy things. Over a period of time the amount R1 and R2 purchased on R3's account was $400.00. R1 and R2 started to avoid R3 because they did not want to repay him. R3 went to R1 and R2's room requesting the money that was owed and R1 attacked R3. Staff heard the commotion, rushed to the apartment and broke up the fight. A few hours later R1 and R2 went to R3's room with the intention of beating him up and threatened to kill him if he ever went into their room. To prevent further interaction between them, the facility decided to pay R3 the money that was owed to him. R1's medical record lacked additional interventions to prevent future incidents. June 9, 2025, at 9:41 a.m., Staff heard and shouting in R1 and R2's room and R2 was yelling that they were going to call the police. Staff rushed downstairs and R1 had R2 pinned down	0 630		

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0 630	Continued From page 24 on the couch and was hitting them with his fists. Staff separated them, but the commotion continued. R1 continued to try and hit R1, the staff told R1 he was going to call the police if the fighting continued. R1 threw something at the staff and R2 went outside. The staff was standing at the entrance, R1 came from behind and punched the staff on the neck and head. The incident occurred between 7:10 a.m., to 7:20 a.m. June 9, 2025, at 9:57 a.m., R1 beat up R2 because they attended bible study with other clients. R1 became angry saying R2 abandoned R1. Staff broke up the fight and R2 begged staff not to get the police involved. R1's medical record lacked additional interventions to prevent future incidents. June 12, 2025, at 9:44 a.m., R1 and R2 threaten to beat, kill or harm staff and other residents when they are angry. R1 and R2 took money and then refused to repay the money and then later threaten to beat up and kill that resident if he went in their apartment. R1 and R2 also threaten to beat up staff or kill them if they were to enter their apartment for any purpose. June 12, 2025, at 2:19 p.m., 2:19 p.m., R1 was taken to the hospital by the authorities because of his violent behavior, physical assault on staff, threatening to beat up other residents. R1 usually blamed his behavior on mental health issues. Therefore, after assault on staff (punches to staff head, and neck, breaking the last windows), his case worker and the facility called the police to take him to the hospital for his violent behavior.	0 630		

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0 630	Continued From page 25 Police records dated June 12, 2025, at 10:35 a.m., indicated R1 was breaking windows and threatening to kill other residents. R1 also assaulted a staff member recently. R1 broke out all of the windows in the home and R1 usually carried a knife with him. R1 was transported to the hospital and placed on a hold. June 17, 2025, at 7:50 p.m., R1 returned from the hospital today. R1's medical record lacked a change in condition assessment or additional interventions to prevent future incidents. June 26, 2025, at 11:10 p.m., R1 attacked the staff tonight. R1 was in a heated argument with R2, and staff attempted to calm the situation, but that made R1 angry. R1's medical record lacked additional interventions to prevent future incidents. July 4, 2025, at 1:37 p.m., R1 became upset and abusive towards staff when R1 thought staff threw something away. July 12, 2025, at 1:35 p.m., R1 and R2 got in a fight this afternoon. R2 accused R1's mother of taking more than $150.00 from her, she got angry, and they both started shouting and insulting one another. Staff tried to stop them. R2 attacked R1 and he got hurt and was bleeding from his mouth and nose. Staff separated them and R1 went to his room. At 1:40 p.m., R2 left the house because they were afraid staff was going to call the police even though staff assured them they would not.	0 630		

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0 630	Continued From page 26 R1's medical record did not include an assessment to identify vulnerabilities, susceptibilities to abuse, or new risks of harm to others. Existing interventions were not evaluated, and no new interventions were implemented to prevent future incidents. August 1, 2025, 1:58 p.m., R1 and R2 moved out of the facility today by 2:00 p.m. Staff assisted packing belonging and gave them their medications. On October 24, 2025, at 1:30 p.m., CM-B stated she did not receive emails from the facility until June with concerns regarding R1 and then all of a sudden in June the licensee wanted to terminate services. CM-B had not been aware R1 had assaulted staff and other residents. CM-B stated after R1 was hospitalized in June, he returned to the licensee. The licensee did not notify her R1 had returned. On October 24, 2025, at 1:30 p.m., case manager (CM)-A stated RN/LALD-E told her she did not call the police because the police would not do anything and usually made the situation more unsafe after they left. CM-A did not know how many times the facility had called the police. RN/LALD-E called and requested a meeting on June 12, 2025, due to R1's increased behaviors and reported R1 was walking around with a knife, and had physically assaulted staff and residents and threatened to kill the residents. CM-A stated she contacted the police due to the concern for the other residents and staff at the facility and encouraged RN/LALD-E to not accept R1 back after hospitalization due to the concern for the other residents residing at the facility.	0 630		

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	30756	A. BUILDING: _____ B. WING _____	C 09/24/2025

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0 630	Continued From page 27 On October 28, 2025, at 3:00 p.m., unlicensed personnel, (ULP)-C stated R1 would threaten staff and residents and tell them he would kill they came in his room. ULP-C stated R1 and R2 were partners and moved in together and shared the same room. ULP-C stated on one occasion he heard R2 shouting and saw R1 standing over and hitting R2. ULP-C stated he got in between them and called LALD, ULP-C stated R1 was a big guy and R2 was smaller. ULP-C stated after that incident R1 came from behind and hit his neck. ULP-C had also witnessed R2 hit R1 ULP-C stated if the residents were fighting the staff were directed to separate the residents and then call the LALD. ULP-C did call the police once, but they didn't do anything. On November 5, 2025, at 1:30 p.m., ULP-D stated he had witnessed R2 lying on the ground and R1 punching them. ULP-D separated R1 and R2, and then R1 went upstairs and broke the window. ULP-D called the nurse, and the nurse calmed them down. ULP-D stated R1 would also become angry and would destroy property. ULP-D stated they were trained to separate the residents and take the aggressive one away and then were to call the LALD/RN and write and incident report. ULP-D stated he didn't call the cops or file a vulnerable adult report. ULP-D stated the incident was documented in the resident's progress note or an incident report. On November 6, 2025, at 10:52 a.m., an email from LALD/RN-E indicated she declined to be interviewed. No further information provided. A policy was requested but not provided.	0 630		

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0 630	Continued From page 28 TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
02310 SS=I	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: Based on interview, and record review, the licensee failed to ensure assisted living services were provided that were appropriate based on the resident's needs and according to an up-to-date service plan and subject to accepted health care standards for three of three residents (R1, R2, R3) with records reviewed, regarding resident to resident altercations. This had the potential to affect all five residents residing on the memory care unit. 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). Findings include: R1 was admitted on November 26, 2024, with diagnoses including schizophrenia,	02310		

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02310	Continued From page 29 post-traumatic stress disorder, and anxiety. R1's service plan dated November 1, 2024, indicated R1 received assistance with dressing, bathing, grooming, medication administration. The plan also included managing anxiety, self-injurious behaviors, verbal aggression, physical aggression, property destruction, and mental health needs. R1's 90-day assessment dated May 24, 2025, indicated R1 was alert and oriented to person, place, time, and situation. R1 was resistive to cares, and medications. R1 had verbal and physical aggression, hostility, defiance, and self-harm. The assessment did not include pharmacological or non-pharmacological interventions. R1's individual abuse prevention plan (IAPP) dated May 24, 2025, indicated R1 was susceptible to abuse from another individuals, including other vulnerable adults. R1 would start fights with staff and other residents. The intervention indicated staff should monitor for signs and symptoms of abuse or neglect from others and report to nurse promptly. R1 also was at risk of abusing other vulnerable adults and liked to start fights with other residents. Staff would intervene and prevent physical violence from occurring by removing the other resident or distracting R1. The intervention indicated staff should monitor R1's behavior and intervene with any actions of abuse toward others. R1 had some identified areas of potential vulnerability, but no signs of abuse or neglect. The plan indicated the interventions were listed on the service plan/care plan.	02310		

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02310	Continued From page 30 R1's care plan record from June 1 to June 30, 2025, indicated if R1 displayed physical violence staff should discuss with R1 alternative ways of expressing emotion and releasing physical energy or tension. R1 needs to learn non-destructive ways to express feelings and release tension. Encourage R1 to increase their physical activity to release tension and plan to continue a regular exercise regimen. Encourage solitary or non-competitive activities to avoid placing R1 in a competitive situation. The manage property destruction tell R1 destroying property was not acceptable. Be clear in the expectations and what the consequences will be if R1 destroys property. Be very clear that frustration is not an excuse for destroying property. Be aware of factors that increase the likelihood of property destruction in R1. Try to help R1 express their feelings in a non-destructive way. The care plan did not identify updated interventions regarding R1's physical violence and property destruction. R1's medical record included the following documentation: R1's progress notes included: January 3, 2025, at 12:22 p.m., an email sent to R1's case managers indicated a serious incident occurred earlier today at the facility when R1's partner (R2) wanted to take the coffee maker to their room. Staff explained the coffee maker was for everyone. After that R1 became extremely agitated and approached staff using profanity and displayed aggressive behavior. R1 attempted to strike staff with a piece of furniture. R1 broke furniture, threw tables, and destroyed the coffee maker. R1 also threatened to	02310		

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02310	Continued From page 31 physically harm staff members making the staff feel unsafe. Police records dated January 3, 2025, at 8:07 a.m., indicated a staff member called 911 and reported R1 was trying to attack the staff and other in the house. R1 did not have a weapon but was throwing things at the staff. R1 was upset about a coffee maker. At 8:33 a.m., police records indicated R1 was in his room and calm and did not need the police to intervene. R1's medical record lacked additional interventions to prevent future incidents. March 22, 2025, at 12:23 a.m., R1 and R2 got into an argument. R1 left to cool down but R2 followed, they got into an argument and then the staff heard a loud bang and saw R1 and R2 were fighting and staff separated them. Staff told R1 to go upstairs. When R1 went upstairs he broke the window. R1's medical record lacked additional interventions to prevent future incidents. March 26, 2025, at 8:34 p.m., R1 went to another client's room and broke the television off the wall and broke other furniture. Staff tried to talk to R1, but he refused to listen. Staff attempted to administer medications but R1 refused. R1 has fought R2. R1 has broken windows, walls and televisions. March 27, 2025, at 11:29 a.m., R1 and R2 came back yesterday and R1 went into another resident's room and broke his 65 inch television and destroyed all the property in his room. R1 and R2 owed R3 $400.00, and when R1 and R2	02310		

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02310	Continued From page 32 found their gaming system was missing and they assumed R3 took it since they owed R3 money. R2 encouraged R1 to engage in violent behaviors and manipulates R1 easily. R2 will attack R1 and then R2 will scream that R1 is attacking R2. R1 has also destroyed numerous 70-inch televisions in the living room and punched numerous holes in the wall again. The property destruction hours can not cover all the property destruction, and the facility needed to be reimbursed for the destruction. Some days R1 refused medications, destroyed property and get physically violent. It appeared R1 was using illegal drugs but has never been witnessed. If R2 tells R1 to become violent R1 will do it. This was an email sent to R1's county case manager. R1's medical record lacked additional interventions to prevent future incidents. March 28, 2025, at 12:16 p.m., staff called R1's provider and explained R1's behaviors including R1 and R2's fight. The staff also informed the provider of the property damage. A referral will be made for a psychiatrist. R1's medical record lacked additional interventions to prevent future incidents. R1's medical record did not include follow up documentation regarding a psychiatrist appointment. April 3, 2025, at 10:32 p.m., R1 and R2 threatened to murder R3. County workers were invited to talk to R1 and R2. The staff showed the health workers violent videos of R1 and R2 fighting and breaking things in the house. The health workers did not take any action. When they left they called and told the nurse to call the	02310		

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02310	Continued From page 33 police. There was no police report record dated April 3, 2025. R1's medical record lacked additional interventions to prevent future incidents. The medical record or facility documents also did not a police report as suggested by the county case workers. April 25, 2025, at 1:23 p.m., R1 and R2 usually threaten to beat up staff. R2 asked for milk and the staff called the supervisor to send supplies, while on the phone R2 attempted to forcefully open another apartment to take the client's supplies. Staff intervened and stopped R2. R2 then told R1 to attack the staff. May 8, 2025, at 9:53 a.m., R1 forcibly entered another resident's room and took the television. R1 broke the televisions in his apartment and the living room and decided to take another resident's television. R1 attempted to hit staff when the staff tried to stop him. May 13, 2025, at 9:09 a.m., R1 broke the downstairs living room television because he did not like the food items in the facilities supply room. R1 and R2 threatened to beat up staff. Staff called the licensed assisted living director (LALD)/registered nurse (RN) to inform her of the concerns. After a few minutes R1 became angry and started breaking the windows, and televisions in the facility. R1's medical record lacked additional interventions to prevent future incidents. June 1, 2025, at 2:56 p.m., R1 was very angry and planning to break all the windows in the	02310		

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02310	Continued From page 34 house because he could not get a ride to see his mom. R1 brought a hammer upstairs and broke a little part of the wall by the kitchen. R1's medical record lacked additional interventions to prevent future incidents. June 2, 2025, at 9:32 a.m., R1 and R2 forcefully broke into another resident's room and took another client's belongings, dresses, and items. June 4, 2025, at 8:20 a.m., R1 threatened to beat up and kill R3 when R3 requested his money back that R1 and R2 owed him. According to the facility investigation, R1 and R2 asked R3 to use his online account to purchase items and they were going to repay him with interest. R3 agreed and let R1 and R2 use his account to buy things. Over a period of time the amount R1 and R2 purchased on R3's account was $400.00. R1 and R2 started to avoid R3 because they did not want to repay him. R3 went to R1 and R2's room requesting the money that was owed and R1 attacked R3. Staff heard the commotion, rushed to the apartment and broke up the fight. A few hours later R1 and R2 went to R3's room with the intention of beating him up and threatened to kill him if he ever went into their room. To prevent further interaction between them, the facility decided to pay R3 the money that was owed to him. R1's medical record lacked additional interventions to prevent future incidents. June 9, 2025, at 9:41 a.m., Staff heard and shouting in R1 and R2's room and R2 was yelling that they were going to call the police. Staff rushed downstairs and R1 had R2 pinned down	02310		

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02310	Continued From page 35 on the couch and was hitting them with his fists. Staff separated them, but the commotion continued. R1 continued to try and hit R1, the staff told R1 he was going to call the police if the fighting continued. R1 threw something at the staff and R2 went outside. The staff was standing at the entrance, R1 came from behind and punched the staff on the neck and head. The incident occurred between 7:10 a.m., to 7:20 a.m. June 9, 2025, at 9:57 a.m., R1 beat up R2 because they attended bible study with other clients. R1 became angry saying R2 abandoned R1. Staff broke up the fight and R2 begged staff not to get the police involved. R1's medical record lacked additional interventions to prevent future incidents. June 12, 2025, at 9:44 a.m., R1 and R2 threaten to beat, kill or harm staff and other residents when they are angry. R1 and R2 took money and then refused to repay the money and then later threaten to beat up and kill that resident if he went in their apartment. R1 and R2 also threaten to beat up staff or kill them if they were to enter their apartment for any purpose. June 12, 2025, at 2:19 p.m., 2:19 p.m., R1 was taken to the hospital by the authorities because of his violent behavior, physical assault on staff, threatening to beat up other residents. R1 usually blamed his behavior on mental health issues. Therefore, after assault on staff (punches to staff head, and neck, breaking the last windows), his case worker and the facility called the police to take him to the hospital for his violent behavior.	02310		

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02310	Continued From page 36 Police records dated June 12, 2025, at 10:35 a.m., indicated R1 was breaking windows and threatening to kill other residents. R1 also assaulted a staff member recently. R1 broke out all of the windows in the home and R1 usually carried a knife with him. R1 was transported to the hospital and placed on a hold. June 17, 2025, at 7:50 p.m., R1 returned from the hospital today. R1's medical record lacked a change in condition assessment or additional interventions to prevent future incidents. June 26, 2025, at 11:10 p.m., R1 attacked the staff tonight. R1 was in a heated argument with R2, and staff attempted to calm the situation, but that made R1 angry. R1's medical record lacked additional interventions to prevent future incidents. July 4, 2025, at 1:37 p.m., R1 became upset and abusive towards staff when R1 thought staff threw something away. July 12, 2025, at 1:35 p.m., R1 and R2 got in a fight this afternoon. R2 accused R1's mother of taking more than $150.00 from her, she got angry, and they both started shouting and insulting one another. Staff tried to stop them. R2 attacked R1 and he got hurt and was bleeding from his mouth and nose. Staff separated them and R1 went to his room. At 1:40 p.m., R2 left the house because they were afraid staff was going to call the police even though staff assured them they would not.	02310		

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02310	Continued From page 37 R1's medical record did not include an assessment to identify vulnerabilities, susceptibilities to abuse, or new risks of harm to others. Existing interventions were not evaluated, and no new interventions were implemented to prevent future incidents. August 1, 2025, 1:58 p.m., R1 and R2 moved out of the facility today by 2:00 p.m. Staff assisted packing belonging and gave them their medications. R2 and R3's medical records were requested, but not provided. On October 24, 2025, at 1:30 p.m., case manager (CM)-A stated the registered nurse (RN)/licensed assisted living director (LALD)-E told her she did not call the police because the police would not do anything and usually made the situation more unsafe after they left. RN/LALD-E called CM-A and requested a meeting on June 12, 2025, due to R1's increased behaviors. and reported R1 was walking around with a knife, and had assaulted staff and residents and threatened to kill the residents. CM-A stated she contacted the police and encouraged RN/LALD-E to not accept R1 back after hospitalization due to the concern for the other residents residing at the facility. On October 24, 2025, at 1:30 p.m., CM-B stated she had not received emails from the facility prior to June 2024, regarding R1's increase in behaviors and then all of a sudden in June the licensee wanted to terminate services. CM-B had not been aware R1 had assaulted staff and other residents. CM-B stated after R1 was hospitalized in June, he returned to the licensee. The licensee	02310		

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02310	Continued From page 38 did not notify her R1 had returned. On October 28, 2025, at 3:00 p.m., unlicensed personnel, (ULP)-C stated R1 would threaten staff and residents and tell them he would kill they came in his room. . ULP-C stated on one occasion he heard R2 shouting and saw R1 standing over and hitting R2. ULP-C stated he got in between them and called RN/LALD-E. ULP-C stated after that incident R1 came from behind and hit him in the head and neck. ULP-C had also witnessed R2 hit R1. ULP-C stated if the residents were fighting the staff were directed to separate the residents and then call the LALD. ULP-C did call the police once, but they didn't do anything. ULP-C stated he had not been directed to make a report to MAARC. On November 5, 2025, at 1:30 p.m., ULP-D stated he had witnessed R2 lying on the ground and R1 punching them. ULP-D separated R1 and R2, and then R1 went upstairs and broke the window. ULP-D called the nurse, and the nurse calmed them down. ULP-D stated R1 would also become angry and would destroy property. ULP-D stated they were trained to separate the residents and take the aggressive one away and then were to call the LALD/RN and write and incident report. ULP-D stated he didn't call the cops or file a vulnerable adult report. ULP-D stated the incident was documented in the resident's progress note or an incident report. ULP-D stated he had not been directed to make a report to MAARC. On November 6, 2025, at 10:52 a.m., an email sent from LALD/RN-E indicated she declined to be interviewed.	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 39 A policy was requested but not provided. 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 three of three residents reviewed (R1, R2, R3) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	