Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL353752560M
Compliance #: HL353759222C

Date Concluded: September 3, 2026

Name, Address, and County of Licensee Investigated:
Ace Homes Inc.
3425 77th Avenue North
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, 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):
The facility neglected the resident when facility staff failed to provide care and services to ensure the resident's safety when the resident goes out into the community.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The facility failed to implement specific interventions regarding the resident's behavioral and safety needs; however, the resident was able her own decision maker and was able to be leave the facility unsupervised. Due to incomplete and conflicting accounts there was not a preponderance of evidence neglect did or did not occur.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, facility incident reports, staff schedules, law enforcement reports, related facility policy and procedures. Also, the investigator observed staff and resident interactions during an onsite visit.

The resident resides in an assisted living facility with current diagnoses including paranoid personality disorder (believing others are lying, cheating or planning to cause harm), schizoaffective disorder (hearing voices, hallucinations, delusions) and suicidal ideations (thoughts, ideas, focus on ending life).

The resident's service plan included assistance with medication management, behavioral management, reminders for dressing and bathing, and assistance setting up transportation. The service plan did not include interventions for how to manage the resident's behaviors. The resident's service plan did not indicate the resident required supervision when leaving the facility.

The resident's assessment and individual abuse prevention plan indicated the resident had severely impaired cognition. The resident was at risk of being abused, abused others and self. The resident was at risk of wandering and heard voices telling them to get on the ground and kneel while in the road. The resident dressed inappropriately for weather and may not find her way home. The resident had a history of attempted suicide and suicidal ideation. The resident's record did not include interventions for assessed vulnerabilities.

Resident progress notes indicated the resident traveled about one hour and thirty minutes one way via a ride share company for a job interview. The resident then did not have funds to return home. The resident contacted facility staff, and they went and picked up the resident.

Police records indicated the resident was found walking in the community and appeared confused and did not know where she lived. The resident was not dressed appropriately for the very cold weather. When police arrived, the resident had already returned to the facility.

After these incidents the residents record was not updated to include interventions to attempt to prevent known vulnerabilities.

During an interview, the case manager stated she had no concerns for the resident. The resident could make her own decisions and did not have a guardian. The resident was able to leave the facility independently. The resident did have a history of unsafe behaviors when out in the community, but the case manager had not heard of any recent concerns.

During an interview, the registered nurse stated when the resident had anxiety or started to act out, staff would de-escalate. The resident did not require supervision to leave the facility and would use public transportation. There was a sign out book at the facility, however residents were not required to sign out when they left. The resident called staff for rides back to the facility and often got lost in the community. The resident had a history of praying in the middle of the road prior to admission but had not occurred for years.

During an interview, the director of an outside agency was not concerned with services the facility provided for the resident but did have concerns when the resident was in the community. The resident would fall asleep on public transportation, get lost in the community, wander the streets, and would give away her belongings, including money.

During the interview, the resident stated she had lived at the facility for six years. Staff were friendly, great listeners, and made sure she was safe. The resident stated she could not go anywhere independently, and staff had to accompany her. The resident had gotten lost on walking trails before but always had her cell phone with.

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: Yes
Family/Responsible Party interviewed: No, declined
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

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
	35375	A. BUILDING: _____ B. WING _____	C 07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACE HOMES INC	3425 77TH AVENUE NORTH BROOKLYN PARK, MN 55443

(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: #HL353759222C/#HL353752560M On July 15, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were three residents receiving services under the Assisted Living license. The following correction order is for #HL353759222C/#HL353752560M, tag identification 0630.	0 000		
0 630 SS=H	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another	0 630		

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0 630	Continued From page 1 individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement or update a person-centered individual abuse prevention plan (IAPP) and identify specific interventions for assessed current and new vulnerabilities for two of three residents (R1, R2). The licensee also failed to include the risk of abuse or the risk of abusing other vulnerable adults for one of one resident (R2) with records reviewed. 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 and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's was admitted on August 5, 2021, with diagnoses including paranoid personality disorder (pervasive distrust and suspicion of others without reason), schizoaffective disorder (mental health condition with hallucinations and delusions), depression, suicidal ideations, and insomnia.	0 630	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.	

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0 630	Continued From page 2 R1's assessment dated September 12, 2025, indicated R1 was agitated and aggressive towards others, decision making was severely impaired and R1 wandered inside and outside. R1's signed home health aide care plan dated November 22, 2025, indicated R1 was independent with dressing, and mobility. R1 required assistance with medication administration, and behavior management. Staff direction for behavior management noted staff should see behavioral health flowsheet. R1's support plan dated May 1, 2026, through April 30, 2027, indicated the licensee received $495.73 for mental health services provided. R1's IAPP dated September 12, 2025, indicated R1 was at risk for elopement, may hear voices asking her to kneel or roll on the floor at times in the middle of the street putting R1 in danger. R1 frequently laid or kneeled in the middle of a street posing for prayers putting her at risk for getting struck by vehicles. R1 had a history of wandering in stores and malls. R1 was at risk of being abused and risk of abusing others with a history of verbally attacking other residents and staff. R1 had a history of suicidal ideations and attempts. R1's assessment or IAPP did not include specific interventions regarding R1's mental health needs or vulnerabilities or how staff would intervene to ensure R1 or R2's safety. R1's care plan dated September 12, 2025, indicated R1 was at risk for elopement. R1 may hear voices asking her to kneel on the floor or in the middle of the street putting herself in danger. R1 also had a history of wandering in stores or malls. R1's care plan did not include specific	0 630	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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0 630	Continued From page 3 interventions regarding R1's mental health needs or vulnerabilities or how staff would intervene to ensure R1's safety. R1's service delivery record dated January 2026, through July 15, 2026, indicated R1 received services including behavior management for agitation, anxiety, self-isolation and wandering but did not include direction or interventions for staff if R1 required behavior management services. The law enforcement report dated December 19, 2025, indicated they were dispatched for a resident with mental health problems. R1 was on the phone with 988 (suicide prevention) reporting she was not eating and was hearing things. Facility staff were not aware that R1 was suicidal or on the phone with 988. R1 reported suicidal ideations and wanted to be hospitalized. R1's incident report dated December 19, 2025, indicated R1 called 911 reporting suicidal ideation but had no specific plan. When law enforcement arrived, it was determined R1 required a psychiatric assessment and was transported to the hospital. The report indicated staff should monitor R1's safety and suicidal ideations and continue scheduled safety checks. R1's medical record was not updated after these incidents to include specific interventions to ensure R1's safety. The law enforcement report dated January 2, 2026, indicated they were dispatched for residents arguing. The report identified R1 chasing another resident around, kicked a garbage can, and threw a magnet at the other resident. R1's medical record was not updated after this	0 630		

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0 630	Continued From page 4 incident to include specific interventions to ensure R1's or other residents' safety. The law enforcement report dated February 21, 2021, indicated they were dispatched for a welfare check to observe R1 since the reporter noticed R1 was confused and not dressed for the weather. R1 did not appear to know where she lived and the reporter was concerned. The report indicated R1 as wearing shorts, clearly underdressed for the weather. When officers arrived at the facility R1 was in her room. R1's medical record was not updated after this incident to include specific interventions to ensure R1 or other residents' safety. R1's progress notes included: - February 13, 2026, indicated R1 was paranoid after taking medications. R1 then left the facility, staff attempted to redirect R1, but she refused. - February 18, 2026, R1 and R2 were arguing today. - February 20, 2026, R1 heard voices all morning and complained of hearing voices. - February 21, 2026, indicated R1 was observed wearing a jacket and shorts despite the cold weather. Staff went outside to check on R1 but were unable to locate her in the immediate area. R1 returned home without incident. While R1 was out walking a neighbor contacted the police with concerns regarding R1's clothing during the cold weather. Law enforcement arrived to complete a welfare check. - March 6, 2026, indicated R1 contacted staff by	0 630		

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0 630	Continued From page 5 phone and reported she took transportation to a job interview approximately 1.5 hours away and did not have funds to get back to the facility. R1 was concerned about her safety and the possibility of being stranded. Transportation was arranged and R1 returned to the facility. - March 9, 2026, indicated R1 missed a psychiatrist appointment. - March 13, 2026, indicated R1 and R2 got at each other. - March 14, 2026, indicated R1 contacted administration and reported that another resident called her names and was being disrespectful. Management investigated the concern and reviewed camera footage and spoke with staff who were present. R1 initiated the interaction and became upset. Staff observed the situation and separated the two residents. - March 22, 2026, 4:32 p.m., indicated R1 and R2 had a heated verbal argument and called each other names. Staff reminded them to be respectful. R1 went downstairs and hit R2's door causing a large hole. Staff took R1 back to her room. R1 was given a verbal warning regarding her behavior. R1's medical record was not updated after this incident to include specific interventions to ensure R1 or other residents' safety. R2 R2 was admitted on October 25, 2023, with diagnoses including schizoaffective disorder, bipolar disorder (mental health condition with significant mood swings), post-traumatic stress	0 630		

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0 630	Continued From page 6 disorder, and suicidal ideations. R2's assessment dated September 12, 2025, indicated R2 required assistance with medication administration and was independent with all other activities of daily living. The assessment indicated R2 was alert and oriented. R2's assessment indicated R2 had a history of attempted suicide or thoughts of suicide and was not at risk of being abused. The assessment did not include specific interventions for known vulnerabilities. The assessment also did not include whether R2 was at risk for abusing others. R2's care plan last updated September 12, 2025, indicated R2 had a history of attempted suicide or thoughts of suicide. R2 had verbal aggression toward staff and residents, screamed at other residents, and demanded other residents obey him. R2 had verbal aggression towards staff and residents daily. R2's care plan did not include interventions for assessed vulnerabilities. R2's progress notes: - January 2, 2026, R2 came upstairs and had verbal agitation, and yelled at R1. R1 turned off the kitchen light and R2 turned on the light and continued to yell. R2 went downstairs and R1 threw a garbage can in the direction of R2 but did not hit him. R2 called law enforcement and requested R1 be arrested. Law enforcement provided de-escalation. - February 27, 2026, R2 was swearing and upset about the housekeeping. - March 1, 2026, R2 was yelling and screaming because there were no eggs. R2 continued to yell and slammed his door repeatedly.	0 630		

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0 630	Continued From page 7 - March 22, 2026, R1 and R2 were in a heated verbal argument and called each other names. Staff separated the residents. R2 then went to the laundry area and used a broom to hit the ceiling to annoy R1. R1 then went downstairs and kicked R2's door. Both residents received a verbal warning for their behavior. - March 23, 2026, R2 awoke and became verbally aggressive towards staff. R2 was observed yelling, screaming and slamming the office door. Staff did not engage and allowed him to express his emotions. - March 24, 2026, a neighbor of the facility came to report R2 to the manager. R2 went in front of his house and called him names and verbally abused him. - April 30, 2026, indicated R2 woke up agitated and accused R3 of taking his heater and he was cold, R3 did not respond and R2 became upset and went upstairs and stomped and screamed. Then went downstairs and began to call R3 and the IHS worker inappropriate names. The IHS staff contacted her supervisor and the police were called. IHS staff reported that R2 called her names and threatened to kill her. - July 16, 2026, indicated R2 accused R1 of eating his food and raised his voice at staff. Staff told R1 to ignore R2. R2's medical record did not include specific interventions to ensure R2 or other residents' safety. On July 15, 2026, at 11:20 a.m., R1 stated she has gotten lost on the walking trails. R1 stated	0 630		

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0 630	Continued From page 8 everything was going well except for another resident that lived in the basement (R2). R1 and R2 have had multiple verbal and physical altercations, staff try to separate them but sometimes didn't work. On July 22, 2026, at 1:36 p.m., registered nurse (RN)-C stated the IAPP should be completed on admission. RN-C did not know what items were required on the IAPP without looking it up on the computer. RN-C stated R1 had behaviors On July 17, 2026, at 2:30 p.m., R1 and R2's case manager (CM)-A stated she was the case manager for R1 and R2. R1 and R2 have been fighting since R2 moved in, including physical fights. CM-A stated facility staff do some broad de-escalation but was not sure of other interventions. At one time R2 wanted to file a restraining order against R1. CM-A did not know how the facility compiled the numbers for the support plan and did not know if facility staff had the correct training for the clientele. On July 21, 2026, at 7:40 a.m., director of an outside agency (D)-B emailed responses and indicated the agency was currently working with R1 on verbal aggressions and boundaries. R1 has fallen asleep on public transportation, gotten lost in the community, wanders the streets in cold weather, and has given away her phone, tables and large sums of money. The director indicated their concern was that facility staff do not step in when R2 interferes and threatens their staff when they are at the facility. The licensee's undated IAPP policy and procedure indicated each resident would be assessed for vulnerability to abuse, and an IAPP would be developed, implemented and reviewed	0 630		

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0 630	Continued From page 9 to minimize risks and promote resident safety. The abuse prevention plan would identify resident-specific risks for abuse and neglect, implement strategies to prevent maltreatment, protect resident rights and dignity, and educate staff. The IAPP will be completed upon admission, new risk factors, following an allegation of abuse or neglect, following hospitalization when risk factors change, annually, and with significant change. Time period for correction: Seven (7) days	0 630		