Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL246751461M
Compliance #: HL246755963C

Date Concluded: July 27, 2026

Name, Address, and County of Licensee Investigated:
West Bloomington Residence
10441 Johnson Avenue South
Bloomington MN, 55437
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, 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 alleged perpetrator (AP) abused the resident when she recorded the resident bathing (showering).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. There was conflicting reports of an incident when the AP assisted the resident to bathe. The resident became angry, took the shower hose, and sprayed the AP. The AP then left the shower room, went into the hallway, took a photo of herself and sent it to a manager. The resident stated she was recorded while in the shower. Although the AP had her cell phone with her, she denied recording the resident. However, the AP also provided a screenshot of a text message that she obtained from someone she sent a message to, but stated she could not recall who that was.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted case workers. The investigation

included review of the resident records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed staffing levels, documentations systems, and camera systems.

The resident resided in an assisted living facility. The resident's diagnoses included epilepsy (seizures), and hemiparesis (paralysis to the left side of her body). The resident's service plan included assistance with bathing, grooming, dressing, and behavior management. The resident's nursing assessment indicated she had paralysis of the left side of her body, and required help applying braces to her left hand and leg. The resident was at risk for falling and used a wheelchair. The resident's memory was intact.

Service delivery records indicated the resident received bathing assistance twice weekly. The AP provided a shower to the resident five out nine times during the month of the allegation.

Progress notes indicated the AP documented an incident after a shower she provided. The AP's documented the resident was upset about the braiding of her hair and sprayed the AP's face and body with water.

A text message screenshot provided by the AP showed a photo of the AP in the hallway of the facility. The AP wore a dark blue "nursing scrub" shirt. The photo showed the AP's hair, face, and upper body soaked with water. The text message following the photo indicated "this is what [resident] did to me" during the shower. The message also indicated the resident began to argue about her hair. The AP said this was the photo she texted to the manager; however, it was a text message screenshot from the recipient, not from the AP's phone, as it had the AP's phone number listed as whom the message was received from.

During an interview, the resident said there were multiple incidences, all tied together. The resident said she became angry with the AP because she wanted the AP to leave her unattended in the shower. The resident said the AP spoke to her aggressively, so she took the shower hose and sprayed her face with water. The resident said after the incident, the AP told her the facility nurses instructed her to record the resident as she showered. The resident said it was sometime after the incident, when the AP recorded her. The resident said the AP went into the shower room, with her cell phone, and told her she was supposed to record her if the resident sprayed her again. The resident said the AP opened the curtain with her cell phone in her hand, as if she was going to record the shower the entire time. The resident said she cussed at the AP, then this stopped.

During an interview, the AP said the resident asked her to braid her (the resident's) hair however she told her she did not have enough time but would do it the following day. The AP said the resident was in the shower, then she [AP] entered the shower area to help her wash, but the resident took the shower hose sprayed her with in her face and cussed at her because she was angry about the hair braiding. The AP said she took a picture of herself and texted the picture to a manager because the resident assaulted her. The AP said she was not in the shower

room when she took the picture. The AP said the manager told her she was sorry this occurred but gave her no instructions to record the resident. The AP said she did not record the resident at any time. The AP was unsure which manager she sent the text, although she obtained the screenshot from this person to provide to the investigator.

It could not be determined which manager or nurse the AP sent the text message or photo to.

During an interview, a nurse manager said she worked with the resident for a long period of time and was unaware of this allegation. The nurse manager said the resident's history included unfounded allegations toward staff.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

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
	24675	A. BUILDING: _____ B. WING _____	C 07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BLOOMINGTON RESIDENCE	10441 JOHNSON AVENUE SOUTH BLOOMINGTON, MN 55437

(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: HL246755963C/HL246751461M On July 9, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were four residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL246755963C/HL246751461M, tag identification 630.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (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 reviewed, the licensee failed to ensure the individual abuse prevention plan (IAPP) included accurate, up to date, interventions to mitigate the risks of harm due to aggressive behavior for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee for diagnoses including epilepsy, adjustment disorder with mixed anxiety and depressed mood, alcohol abuse, and hemiparesis affecting the left side. R1's service plan dated April 2, 2024, indicated	0 630		

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0 630	Continued From page 2 R1 required assistance with bathing, dressing, grooming, housekeeping, and behavior management. R1's behavior contract dated July 29, 2025, indicated R1 agreed to obtain a physician's order for alcohol consumption. The contract indicated R1 agreed staff would remove alcohol from her room, if they observed it. The behavior contract indicated R1 would express her frustrations without swearing. R1's progress notes dated December 1, 2026, through March 31, 2026, indicated R1's behavior included yelling, cussing, and physical aggression. Progress notes also indicated R1's behaviors included accusatory statements, unfounded by video footage. R1's customized living rates worksheet dated February 1, 2026, through January 31, 2027, indicated R1 was "very" verbally abuse. R1 had a "significant" history of substance abuse and required continued nursing oversight and monitoring due to chemical dependency. R1 bought "gummies" and sold them to other residents. R1's IAPP dated June 4, 2026, inaccurately indicated R1 did not pose a risk of abuse to any other vulnerable adults. The IAPP indicated R1 abused alcohol, however lacked any interventions to manage this. The IAPP failed to identify R1 was "very" verbally abusive as indicated in customized living worksheet. The IAPP did not indicate R1 was physically abusive. The IAPP lacked indication the licensee completed a behavior contract with R1. The IAPP failed to identify R1's behavior when she consumed alcohol, or further interventions staff would/should	0 630		

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0 630	Continued From page 3 implement to manage R1's alcohol consumption. On July 14, 2026, at 11:43 a.m., registered nurse (RN)-A said she worked as the primary nurse for the licensee at this location and knew R1 for years. RN-A said R1 had increased behavior issues when she used alcohol which her difficult to manage. RN-A said R1 obtained a physician's order to manage her own medications, but due to her alcohol consumption, she mis-managed her medications. This resulted in seizures and hospitalizations. RN-A said R1 made multiple unfounded allegations. The licensee's policy titled, Individual Abuse Prevention Plans, no date, indicated the licensee would develop specific measures minimize the risk of abuse to vulnerable adults. Time period for correction: Seven (7) days.	0 630		