DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL285582700M
Compliance #: HL285589840C

Date Concluded: April 29, 2026

Name, Address, and County of Licensee Investigated:
The James Inc
10549 Beard Avenue South
Bloomington, MN 55431
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Katherine Barnhardt RN, Special Investigator

Finding: Not Substantiated

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The alleged perpetrator (AP), a facility staff, abused the resident when the AP threw a milk carton at the resident. Additionally, facility staff neglected the resident when food supplies and wound care were not provided.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse and neglect were not substantiated. There was no evidence to support the AP abused the resident. At the time of the incident, police were contacted and the resident admitted he threw a milk carton at the AP. Additionally, food was provided, and an outside agency managed the resident's wound care services.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, a fire department and a mental health representative. The investigation included review of the resident record(s), hospital records, pharmacy records, facility internal investigation, facility

incident reports, personnel files, staff schedules, law enforcement reports, fire department reports, related facility policy and procedures. Also, the investigator observed facility staff interact with and provide direct cares to residents.

The resident resided in an assisted living facility. The resident's diagnoses included paraplegia and borderline personality disorder. The resident's service plan included assistance with range of motion exercises, showers and meal prep. The resident's assessment indicated the resident was able to make needs known and understood others. The assessment indicated the resident used an electric wheelchair and was independent with decisions. The resident was resistive to care, had a history of defiance, physical and verbal aggression and hostility.

The resident record indicated the resident became angry with the AP when the AP declined to provide range of motion exercise assistance for a fifth consecutive time during one session. The resident threatened the AP and stated, "so you do not listen to me, wait, you will see." The AP went to the main living area and sat down to chart. The resident approached the AP from the back and poured urine over the AP from the resident's urinal. The resident then dumped cartons of protein milkshakes and a liquid throughout the main living area, walls, dining room table, chairs and floor. The AP and the resident called 911. Law enforcement and paramedics responded.

Law enforcement reports indicated the resident called 911 and reported he was struck by a milk carton thrown by the AP. The AP called 911 and requested assistance with the resident. On arrival law enforcement reported the facility in disarray, numerous milk cartons broken and lying on the floor around a kitchen area. Milk was splattered on the floor, walls and on the AP. Law enforcement reported the resident stated he was "acting like a child to get back at staff" and had thrown milk cartons against the walls, the floor and the AP.

During an interview, the AP stated the resident was angry with the AP when he stopped assisting with range of motion exercises. When the AP went to the main living area to sit down and chart information, the resident approached him from behind and poured urine on him. The AP called 911 for assistance and denied throwing anything at the resident.

During an interview, the resident stated range of motion exercises was four times a day. The resident stated he called 911 when the AP threw a bottle of milk at him. Law enforcement arrived and he was taken to a hospital for a medical hold. The resident stated when angered he sprayed condiments throughout the facility and on staff vehicles. The resident stated the stove was not operable. The resident reported he did not like the facility options and had snacks in his room. The resident stated an outside agency provided wound care.

During an interview, a licensed staff member stated the resident kept a blender in his room and would blend foods with urine and spray it around the facility and on staff. The day of the incident the resident threw protein milkshakes at the AP and poured them all over the facility. Law enforcement was called, and the resident was taken to a hospital for a mental health

evaluation. The resident returned to the facility the next morning. A licensed staff member stated the facility was unable to keep food in kitchen cabinets or the refrigerator, however, food supplies were kept on a lower level of the facility. When food was kept on the main level, the resident removed the food, threw it on the floor and smashed it every day with his electric wheelchair. A licensed staff member stated the resident's wound care was provided by an outside agency and the resident would not allow facility staff to assist with wound care.

In conclusion, the Minnesota Department of Health determined abuse and neglect were not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means: …
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

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

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Vulnerable adult is own person
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility provided alternative food options and summoned law enforcement for safety assistance.

Action taken by the Minnesota Department of Health:

No further action taken at this time.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28558	A. BUILDING: ______ B. WING ______	C 04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JAMES INC	**10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431**

(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: #HL285582700M/#HL285589840C and #HL285582881M/HL285581355C On April 7, 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 six residents receiving services under the provider's Assisted Living license. No correction orders are issued for #HL285582700M/ #HL285589840C. The following correction orders are issued for #HL285582881M/HL285581355C, tag identification 2360.	0 000	Assisted Living Provider 144G. 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.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Minnesota Department of Health

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02360	Continued From page 1	02360		
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: Based on observation, interviews, and document review, the facility failed to ensure six of six residents reviewed (R1, R2, R3, R4, R5, R6) were free from maltreatment. Findings include: On April 7, 2026, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		