DEPARTMENT OF HEALTH

STATE LICENSING COMPLIANCE REPORT

Report #: HL285585388C

Date Concluded: March 30, 2026

Name, Address, and County of Facility Investigated:

The James Inc
10549 Beard Avenue South
Bloomington, MN 55431
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: James Larson, RN
Special Investigator

Nicole Myslicki, 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.

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 02/10/2026

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: #HL285583549C, HL285585420C, HL285585388C On February 10, 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. The following correction orders are issued for #HL285583549C, tag identification 460, 480, 570, 590, 800, 830, and 2480.	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

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0 460	Continued From page 1	0 460		
0 460 SS=D	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure one of six residents (R6) was provided a means to request assistance for health and safety needs 24 hours per day, seven days per week. 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).	0 460		

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0 460	Continued From page 2	0 460		

The findings include:

R6 admitted to the licensee May 22, 2025. R6's diagnoses included diabetes mellitus II, schizophrenia, glaucoma, and cataracts. R6's service plan dated May 22, 2025, indicated R6 received assistance with managing mental health symptoms. R6's assessment dated January 12, 2026, and signed December 12, 2026, identified R6 of having a visual impairment and cognitive impairment.

During a tour of the facility on February 10, 2026, at approximately 10:45 a.m., an observation of the lower level bedroom occupied by R6 the investigator was unable to locate a call pendant or call assist device in the room. When asked about the location of any call assistance devices, R6 stated there was not one and was not able to recall if there ever had been one in working order.

During an interview on February 10, 2026, at 11:47 a.m., registered nurse (RN)-B stated there had been one adhered to the wall previously and confirmed that there was not one now. She had only been made aware that R6 did not have a call light when the investigator informed her.

The licensee's Resident Call Light System policy, undated, indicated the licensee would ensure all residents had a reliable, accessible means to summon staff assistance twenty-four (24) hours per day.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

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0 480	Continued From page 3	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480		

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0 480	Continued From page 4 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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 the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated March 28, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one	0 480		

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0 480	Continued From page 5 (21) days	0 480		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to display the current facility licenses at the assisted living facility as required. This had the potential to affect all of the licensee's current residents, staff and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), 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: On February 10, 2026, during a facility tour at approximately 10:00 a.m. an observation of the facility's common areas noted the lack of the required posting of the current assisted living license, the current licensed assisted living director, or the current food manager license near the entrance common area of the facility. Each license was displayed although all were expired. On February 10, 2026, during a facility tour at approximately 10:00 a.m. RN B verified the	0 570		

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0 570	Continued From page 6 required information was not up to date in the common areas of the facility. The facility failed to display the original current licenses at the assisted living facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 590 SS=D	144G.42 Subd. 3 Facility restrictions (a) This subdivision does not apply to licensees that are Minnesota counties or other units of government. (b) A facility or staff person may not: (1) accept a power-of-attorney from residents for any purpose, and may not accept appointments as guardians or conservators of residents; or (2) borrow a resident's funds or personal or real property, nor in any way convert a resident's property to the possession of the facility or staff person. (c) A facility may not serve as a resident's legal, designated, or other representative. (d) Nothing in this subdivision precludes a facility or staff person from accepting gifts of minimal value or precludes acceptance of donations or bequests made to a facility that are exempt from section 501(c)(3) of the Internal Revenue Code. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee's administrator (AD)-A served as representative (rep) payee for one of six residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 590		

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0 590	Continued From page 7 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: R6 admitted to the licensee May 22, 2025. R6's diagnoses included diabetes mellitus II, schizophrenia, glaucoma, and cataracts. R6's service plan dated May 22, 2025, indicated R6 received assistance with managing mental health symptoms. During an interview February 10, 2026, at 10:14 a.m., R6 stated AD-A was listed as her rep payee. During email correspondence February 13, 2026, at 3:21 p.m., AD-A indicated he has been assisting R6 to get her money and pay her rent with her supplemental security income (SSI) money until she obtained another rep payee. The licensee's Handling of Resident Finances and Property policy, dated November 15, 2021, indicated the licensee would not manage a resident's property aside from assisting with simple financial tasks such as paying bills. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 590		
0 800 SS=G	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 8 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, in a continuous state of good repair and operation. This had the potential to affect all staff, residents, and visitors. 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 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: A fire department report dated December 18, 2025 indicated the fire department responded to a call at the facility. The report included that a resident was stuck on the ramp to get into the home. Fire department assisted the resident up the ramp and into the home. Resident reported to fire department that staff do not help him up the ramp when he is stuck. Staff reported it was the managers job and she did not have the proper footwear. Staff reported she does help but only	0 800		

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0 800	Continued From page 9	0 800		

had a broom to push snow.

A fire department report dated January 15, 2026 indicated the fire department responded to a call at the facility. The report included that a resident was stuck in the driveway. Fire department assisted resident into the home.

A fire department report dated January 19, 2026 indicated the fire department responded to a call at the facility. The report included that a resident was unable to get up icy ramp, helped push him up the ramp into the house.

A fire department report dated January 21, 2026 indicated the fire department responded to a call at the facility that a resident was stuck on the ramp and staff would not help. The report indicated fire department assisted getting his wheelchair up ramp. Staff met the fire department outside and say they can and do help him but he did not call them. He is unharmed and needs no further assistance.

A fire department report dated January 22, 2026 indicated the fire department responded to a call at the facility. The report included resident had concerns about electrical hazzards in the group home. Fire department noted that almost none of the wall outlets throughout the house had covers and exposed electerical components were visible. The home also had smoke dertectors chirping in low battery mode and wheel chair ramps in disrepair.

On February 10, 2026, during a facility tour at approximately 10:00 a.m. the investigator made the following observations of the facility which included:

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0 800	Continued From page 10	0 800		

Continued From page 10

1. The sidewalk adjacent to the main entrance where the handicap accessible ramp met the sidewalk was sunken and uneven.

2. The sliding door leading from the kitchen to the rear patio was missing a door handle and was not able to be opened properly when tested.

3. Cabinetry and appliances in the food prep area were missing handles and knobs and were not able to be opened properly when tested.

4. The wooden ramp inside the facility adjacent to the main entrance that led to the kitchen was in disrepair.

5. The protective electrical outlet cover was broken from the wall outlet in R3's room.

6. The staircase leading from the main floor down to the basement was missing a backing plate midway up the staircase as well as separation along multiple stairs.

7. The floors, walls and surfaces throughout the facility were visibly discolored in areas. Visible dirt could be seen along the floorboards, stairs and windowsills, with surfaces being discolored. Surfaces were not maintained in a sanitary condition.

8. The bathroom exhaust fan vent cover was falling down resident room #6.

9. The main level bathroom sink's drain stopper was broken. Dirty water sat in the sink bowl and could not drain.

During the on site visit on February 10, 2026 registered nurse (RN)-B verified during walk

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0 800	Continued From page 11 through and interviews of these deficient conditions. During an interview on February 10, 2026, at 11:47 a.m., RN-B stated the facility would be getting a new dishwasher. The bottom of the ramp would be replaced because it had just broken. RN-B acknowledged the dirty walls. RN-B stated she did not know about the sink stopper not working. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking indoors. This had the potential to affect all residents.	0 830		

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0 830	Continued From page 12	0 830		

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:

During the facility tour on February 12, 2026, at 9:55 a.m., the investigator observed several cigarette butts were scattered on the ground in front, on the side, at the entrance of the facility.

During an observation on February 10, 2026, at 10:21 a.m., R5's room had several cigarette butts throughout the bedroom and ash on the floor. The investigator observed R5 smoking a cigarette while laying in his bed. R5 shook his ash off his cigarette onto the floor in between his bed and the wall.

During an observation on February 10, 2026, at 10:30 a.m., the investigator observed R4 and R5 entering the attached garage. A strong odor of cigarettes and marijuana could be smelled at the time of the observations.

During an observation on February 10, 2026, at 10:45 a.m., several cigarette butts were scattered on the floor of the garage.

During an interview on February 10, 2026, at 10:21 a.m., R5 stated they were not supposed to smoke in their rooms. However, when he did, staff just let it be.

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0 830	Continued From page 13	0 830		

During an interview on February 10, 2026, at 10:32 a.m., R2 stated that although the residents were not supposed to smoke in their rooms, licensed assisted living director (LALD)-A had been lenient about it and did not care.

During an interview on February 10, 2026, at 11:30 a.m., registered nurse (RN)-B stated she asked the residents not to smoke in their respective rooms or in the attached garage, but they do it anyways. She went on to state that the facility has attempted to implement smoking rules, but all have failed due to resident noncompliance.

The licensee's Smoking Policy dated July 1, 2022, indicated smoking, tobacco, and e-cigarette use is prohibited at The James Inc Assisted Living.

The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited indoors of all public places to include health care facilities and clinics. MCIIA defined "Indoor Area" to be "a space between a floor and a ceiling that is at least half enclosed by walls, doorways or windows (open or closed) around the perimeter. A wall includes retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier."

State statute 144.414 Prohibitions; Subdivision 3 Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a

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0 830	Continued From page 14 designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 830		
02310 SS=G	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 document review the licensee failed to ensure appropriate care and services were provided in accordance with an up-to-date service plan subject to accepted health care standards for residents who were smoking in the facility. 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 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: On February 10, 2026 a complaint investigation	02310		

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was initiated at the facility.

During a tour of the facility on February 10, 2026 at 10:21 a.m. R5 was observed in his room. R5 was sitting on his bed, smoking a lit cigarette. R5 ashed the cigarette out on the side of the bed against the wall. R5 stated he was not allowed to smoke in here, but when I do, they [the staff] just let it be. R5 then put his cigarette out and threw it on the floor. The investigator took a picture of the cigarette discarded on the floor.

R2 was interviewed at 10:32 a.m. on February 10, 2025 and stated that residents were not supposed to smoke in the facility but the owner doesn't care what we do; he's lenient.

R2's undated 90-day assessment indicated R2 was independent with smoking, smoked traditional cigarettes and could appropriately handle lit smoking material, was able to safely use a lighter and/or matches, and understood and can locate designated smoking areas. The assessment indicated R2 had no history of smoking in unapproved areas and no history of smoking issues or concerns. The assessment indicated R2's smoking materials were to be kept/locked at the nurses station.

R2's individual abuse prevention plan (IAPP) dated April 21, 2025 indicated R2's room was littered with garbage with personal clothes all over the floor in his room, other times with tobacco stains on the floor. No approach or intervention was identified for this vulnerability. R2's IAPP identified under Repetitive Behavior staff were to encourage and redirect R2 to smoke in designated areas. No additional information related to smoking, and no intervention or approach was identified related to smoking in this

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area. The IAPP identified there were concerns with safe smoking as R2 had smoked in her room and set off the smoke alarm. The intervention listed was for staff to hold R2's smoking material in the medcart/room and encourage smoking cessation. The IAPP indicated interventions related to vulnerabilities were identified on the service plan or care plan.

R2's service plan dated October 27, 2025 included daily management of repetitive behavior but did not indicate services related to smoking.

R4's November 3, 2025 assessment documented R4 was "back to smoking". The assessment indicated R4 smoked E-cigarettes, had a history of smoking in undesignated areas noted with "smokes in his room all the time" and had a past history of smoking concerns noting R4 "refuse to be in compliance". The assessment indicated R4 could appropriately handle lit smoking material, was able to safely use a lighter and/or matches, and understood and can locate designated smoking areas. The only intervention listed was to remind resident to smoke in designated areas only. No additional interventions were listed related to smoking on the assessment.

R4's November 12, 2025 individual abuse prevention plan (IAPP) was marked FALSE under "Concerns with safe smoking" but included Resident to will safetly smoke in designated area. No vulnerabilities related to smoking were identified on R4's IAPP.

R4's November 2, 2025 Service Plan did not include services related to smoking or smoking behaviors.

R5's December 15, 2025 assessment indicated

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R5 was independent with ambulation, transfers,and mobility, was alert and oriented and able to communicate his own needs. The assessment included a safe smoking assessment indicating R5 could appropriately handle lit smoking material, was able to safely use a lighter and/or matches, and understood and can locate designated smoking areas. The assessment indicated R5 smoked traditional cigarettes and had no past history of smoking concerns. The assessment indicated R5 had a history of smoking in unapproved areas/apartment and documented under this area "forgetful". The assessment further indicated staff were to remind R5 to smoke in designated areas and that smoking materials were kept/locked at nurses station. No additional interventions were included under the smoking area of the assessment.

R5's individual abuse prevention plan (IAPP) dated April 29, 2025 indicated R5's environment was not always safe and clean noting that R5's room was littered with garbage and tobacco stains were on the floor. The IAPP indicated staff were to provide housekeeping services and keep the area free of clutter. No additional interventions were included related to the tobacco use/stains on the floor. The IAPP indicated there were concerns for safe smoking and noted R5 smoked inside the facility, inside his room and set off the smoke alarm, and cigarette burns on the floor in his room. The intervention listed included for staff to hold his smoking materials in med cart/room. No additional interventions related to smoking were identified on the IAPP. The IAPP indicated interventions for identified areas of vulnerability could also be found on the service plan or care plan.

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02310	Continued From page 18 R5's service plan provided to the investigator was dated October 27, 2024 and included no service related to smoking or smoking behavior. Interview with Registered Nurse (RN) on February 10, 2026 at 11:47 a.m., stated she tells residents to not smoke in the house but since one resident came in, they all smoke in their rooms. Joy indicated interventions for smoking included giving terminations notices, and taking away cigarettes/lighters to provide when residents want to smoke outside but indicated residents started smoking in their rooms after R4 did and said R4 doesn't listen [about smoking in the house] he just keeps doing what he wants.	02310		
02480 SS=D	144G.91 Subd. 20 Grievances and inquiries Residents have the right to make and receive a timely response to a complaint or inquiry, without limitation. Residents have the right to know, and every facility must provide the name and contact information of the person representing the facility who is designated to handle and resolve complaints and inquiries. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to respond to grievances for one of six resident (R4) reviewed for grievances. R4 communicated several concerns to the licensee without resolution. 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	02480		

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resident's health or safety) 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:

R4's diagnoses included personality disorder, major depression, anxiety, paraplegia.

R4's Service plan signed November 2, 2025, indicates the facility will manage anxiety, agitation, verbal aggression, physical aggression, property destruction, self-injury behavior and repetitive behavior daily.

R4's nursing assessment dated November 17, 2025, indicates behavioral symptoms/ expressions include resistance to cares, verbal and physical aggression, hostility, defiance with angry outburst.

On February 19, 2026, R4 forwarded the investigator several emails he sent to licensed assisted living director (LALD)-A making complaints. None of the emails included responses from LALD-A.

- In an email sent from R4 on December 29, 2025, at 10:19 p.m., titled "grievance", R4 informed LALD-A of a complaint regarding registered nurse (RN)-B taking all his food and putting it in the kitchen refrigerator, even though R4 asked her not to touch his food. R4 felt concerned someone would steal his food, which they did.

-In an email sent from R4 on December 29, 2025, at 10:28 p.m., titled "grievance", R4 informed

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LALD-A that RN-B put her hands on him, threw his phone, and hit his feet with a door.

-In an email sent from R4 on December 30, 2025, at 3:18 p.m., titled "recorded me using the bathroom", R4 informed LALD-A he kept asking RN-B to stop putting his food in the kitchen refrigerator due to concerns of someone eating it. Another resident did eat his food. R4 also indicated RN-B also recorded him using the bathroom on her personal phone. R4 requested action be taken due to his rights being violated.

-In an email sent from R4 on January 18, 2026, at 12:06 a.m., titled "grievance #4 deadline is the 26th", R4 informed LALD-A that staff were only helping him the way they wanted, not the way he needed them to help. R4 indicated this had been an ongoing problem since he had been there.

-In an email sent from R4 on January 22, 2026, at 3:57 p.m., titled "fired hazard", R4 informed LALD-A that his property had been damaged weeks prior, and it has been a fire hazard. R4 indicated it needed to be replaced, as he could not go without his necessities.

-In an email sent from R4 on January 30, 2026, at 12:11 p.m., titled "grievance/heads up", R4 informed LALD-A that he had an urgent concern regarding a specific staff member. He did not feel comfortable receiving care from her. She frequently failed to comprehend or perform basic tasks, and he felt that this neglect put him at risk. R4 also asked to not have her as his caregiver anymore.

-In an email sent from R4 on February 2, 2026, at 10:50 a.m., titled "emergency meeting", R4 informed LALD-A he was requesting a meeting as

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soon as possible. R4 indicated his emails were "clearly being ignored", he has asked to not be around the previously specified staff member, and wanted the meeting for his safety and comfortability.

-In an email sent from R4 on February 11, 2026, at 8:16 p.m., titled "grievance #8", R4 informed LALD-A it seemed as though only two staff knew how to perform his range of motion, and the rest still did not understand. Additionally, most of the female staff developed hand injuries and could perform any services except his range of motion. R4 also indicated the staff did not clean the facility properly and only used water.

On February 10, 2026, the investigator requested to review facility grievances log for time period of (October 2025 - February 2026) from LALD-A. None were received.

On February 12, 2026, the investigator again requested to review facility grievances log for time period of (October 2025 - February 2026) from LALD-A. None were received.

-In an email sent from R4 on February 17, 2026, at 12:32 p.m., titled "Re: Grievance 11 staff assaulted me", R4 informed LALD-A a staff member picked up an Ensure milk drink and threw it at him. The drink hit him, and there was milk from his shoulder down to his feet. R4 also mentioned to others on the email chain, he did not think LALD-A would respond.

During email correspondence on March 3, 2026, at 10:37 a.m. LALD-A indicated no resident had ever requested a grievance form or filled one out.

The licensee's Complaint/Grievance Policy dated

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02480	Continued From page 22 July 21, 2021, indicated 1. A facility complaint form should be filled out by the resident, resident representative, or employee and given to the Assisted Living Director: 2. If a resident, resident representative, or employee cannot, for any reason, fill out a complaint form one will be completed on their behalf by the supervisor or Assisted Living Director. 3. When possible and reasonable, the complaint will be resolved immediately involving others as needed. 4. If needed, an investigation surrounding the facts of the complaint shall be initiated. 5. During the investigation process, and when possible, residents, resident representatives, or employees will be asked to participate in determining the solution and bring about resolution of the complaint. 6. After an investigation is complete, a prompt response to the resident, resident representative, or employee complaint or concern will be provided verbally and, if desired, in writing. Residents or employees will be given a reasonable explanation for the action taken on their behalf. 7. In a case where maltreatment was identified (abuse, neglect, or exploitation), a staff of Golden Maple Home will promptly contact the Minnesota Adult Abuse Reporting Center (MAARC) to make a report. MAARC phone 1-844-880-1574 for more information: https://mn.gov/dhs/adult-protection/ 8. If the resolution of a complaint results in a system or procedure change, the change shall be made and communicated appropriately to employees or residents, keeping the confidentiality in mind.	02480		

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02480	Continued From page 23 9. Finalized resident complaints will be kept in the resident record. Finalized employee complaints will be kept for 3 years then disposed of. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	02480		