Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL295046928M
Compliance #: HL295041828C

Date Concluded: May 13, 2025

Name, Address, and County of Licensee Investigated:
Morning Glory Homes Inc.
18626 Clearview Drive
Minnetonka, MN 55345
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, 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) abused a resident when the AP told the resident to find another place to live if the resident was not happy and did not trust staff.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the AP told the resident to find another place to live if the resident was not happy and did not trust staff, the allegation did not rise to the level of abuse.

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

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia, autism, and chronic fatigue syndrome. The resident's service plan included assistance with dressing, grooming, bathing, medication and behavior management, and safety checks. The resident's assessment indicated the resident was alert, oriented, and independent with decision making.

An audio recording indicated management staff told the resident they needed to find another place to live if the resident did not trust the staff. Management also told the resident he was unhappy that the resident was recording conversations, and he was having trouble keeping staff since no one wanted to help the resident.

A police report indicated a manager yelled at the resident and the resident felt unsafe. The police called the resident and the manager and mediated the situation.

During an interview, management staff stated he did tell the resident to find another place to live if the resident was not happy and did not trust staff. He had just found out the resident had been secretly recording facility staff and was upset. The facility had lost staff because the resident constantly changed how staff should provide services. Management stated that facility staff did the best they could and the resident was planning to move out prior to the incident to reside in a more independent setting.

During an interview, the resident stated that they expressed concerns via email and shortly after that, management staff came into the resident's room and told them if they were not happy and did not trust staff they would have to leave. The resident had a panic attack a couple hours after this incident. The resident stated prior to this incident they had already decided to leave the facility for a setting that allowed increased independence but moved out earlier than planned since the resident felt uncomfortable.

In conclusion, the Minnesota Department of Health determined abuse was 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:
(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: No, per resident request.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
No further action taken at this time.

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
	29504	A. BUILDING: _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING GLORY HOMES INC	18626 CLEARVIEW DRIVE MINNETONKA, MN 55345

(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: #HL295041828C/#HL295046928M On March 13, 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 Assisted Living license. The following correction order is issued/orders are issued for #HL295041828C/#HL295046928M, tag identification 2350.	0 000		
02350 SS=G	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced	02350		

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02350	Continued From page 1 by: Based on interview, and document review, the licensee failed to ensure one of one resident (R1) was treated in a courteous, respectful, and dignified manner. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 was admitted to the facility on September 5, 2023, with the diagnoses including schizophrenia, autism, and chronic fatigue syndrome. R1's signed facility contract dated September 16, 2023, included the Assisted Living Bill of Rights including; residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect. R1's 90 day assessment dated November 30, 2024, indicated R1 was oriented, and independent with decision making. R1's unsigned master care plan dated November 30, 2024, indicated R1 received staff assistance with activities of daily living including, dressing, grooming, bathing, and skin care. R1 also received assistance with medication management, behavior management and safety checks.	02350	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.	

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02350	Continued From page 2 Audio recording of R1 and licensed assisted living director (LALD)-A indicated LALD-A stated, "you need to find another place, if you don't trust us, go, ok?, do you understand?" R1, responded yes. LALD-A stated "and I'll tell you this, when I was working the other night and you kept peaking on me and that, I don't appreciate it". R1 stated, "I don't know what you are talking about." LALD-A stated, " you were checking to see if I was sleeping." R1 stated, " I wasn't, LALD-A stated, "yes, you were." R1 replied, "no I wasn't." In a louder tone of voice, LALD-A stated "stop looking for problems, you're not happy here, you move. I'm not happy with you, to record people is very distrustful, you say you don't trust the staff, well guess what, I am having problems keeping people, nobody wants to help you, find a place to move." A police report dated November 20, 2024, at 12:10 p.m. indicated a manager yelled at R1 and R1 felt unsafe. A mediated phone call was made to R1 and LALD-A. On April 1, 2025, at 11:05 a.m., LALD-A confirmed he did tell R1 that if she was not happy to find another place to live and no staff wanted to work with R1. He had just found out R1 had been secretly recording the staff and stated, "I was so furious," it was so hard to find staff and they staff would leave because of R1. LALD-A stated the staff did the best they could to provide services for R1, but R1 would constantly make changes in care needs. LALD-A stated prior to this incident R1 had requested to move to another location where she could be more independent. On April 3, 2024, at 11:00 a.m., R1 stated they had sent an email to LALD- regarding her	02350		

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02350	Continued From page 3 concerns and about 10 minutes later, LALD-A went into R1's room and told R1 he was not happy that she recorded people and if R1 was not happy and did not trust staff then R1 would need to find another place to live. After LALD-A left R1's room, R1 stated they had a panic attack for hours. R1 attempted to call the ombudsman, county case manager, and the disability hub. The police were called by an outside agency and a police officer called R1 and LALD-A. R1 stated the police did not help the situation and there was no resolution. After the incident R1 requested staff let them know when LALD-A would be coming to the facility since they were uncomfortable. After that incident R1 stated they moved out sooner than expected due to the incident since R1 did not feel safe. The licensee provided Bill of Rights for the Assisted Living Residents dated, August 1, 2022, indicated under Applicability: (4) Courteous treatment: Residents had the right to be treated with courtesy and respect. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (7) days	02350		