Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL329916662M
Compliance #: HL329915809C

Date Concluded: March 25, 2026

Name, Address, and County of Licensee Investigated:
Harbor Crossing
4650 Centerville Road
White Bear Lake, MN 55127
Ramsey County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Jennifer Segal, RN, BSN
Special Investigator

Finding: Substantiated, facility responsibility

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 resident-1 and resident-2 when they failed to provide adequate supervision. Consequently, resident-2 physically assaulted resident-1, resulting in hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to provide supervision to protect residents' (resident-1 and resident-2). The facility was aware resident-2 exhibited violent and aggressive behaviors and wandered into other residents' rooms and failed to identify and implement interventions to mitigate future incidents. The facility failed to supervise, assess and implement interventions to protect the health and safety of resident-1 and resident-2.

The investigator interviewed facility staff, including administrative, nursing, and unlicensed personnel. The investigator contacted law enforcement and the families of both residents. The investigator reviewed medical records for both residents, including resident-1's hospital and death record, the facility investigation, incident reports, training records, and related facility policies and procedures. The investigator also reviewed live-stream audio and video of the incident before, during, and after the altercation and observed care provided in the memory care unit.

Resident-1 lived in the assisted living memory care unit with diagnoses including dementia. The service plan included assistance with all personal care and safety checks. The nursing assessment indicated resident-1 had poor vision, required a walker, and required staff assistance with mobility. Resident-1 could communicate her needs and needed some help with decision-making. Nursing identified resident-1 was vulnerable and at risk of abuse and neglect by others.

Resident-2 lived in the assisted living memory care unit with diagnoses including Alzheimer's disease, severe dementia with agitation, depression, and anxiety. The service plan included safety checks, assistance, and supervision with all personal care. The nursing assessment indicated that resident-2 was agile and independent with mobility, had difficulty communicating her needs, was confused, and had a history of agitation and physical aggression toward others. Nursing identified resident-2 had vulnerabilities including being abused and neglected, or abusing others.

Medical records indicated resident-2 moved into the facility and within the first day, unlicensed staff noted resident-2 was agitated, anxious, wandering, refusing assistance, and difficult to redirect. Family reported resident-2 was previously prescribed a benzodiazepine (fast-acting medication for anxiety), and family would administer to help decrease anxiety and agitation. Unlicensed staff documentation continued with frequent notes indicating resident-2 continued to be anxious, agitated and redirection and medication was not effective.

A nursing assessment completed 15 days after admission indicated resident-2 attempted to leave the secure unit, wandered, showed anxiety, cried, and invaded others' personal space. Resident-2's interventions included redirection, as-needed medications, and music. The assessment indicated resident-2 was vulnerable, at risk of abuse, and did not pose a danger to the health and safety of others. The assessment indicated resident-2 was stable, had no change in condition and the care plan remained appropriate.

Post assessment progress notes indicated that unlicensed staff continued to report that resident-2 had ongoing aggression, entered other residents' apartments, invaded others' personal space, and was difficult to redirect. Staff noted medications and other interventions were ineffective.

Medical records indicated a facility nurse contacted the provider to request a medication change due to resident-2's continued aggression and entered other residents' apartments uninvited. When staff tried to redirect resident-2, she was physically resistive, and staff reported being kicked at and hit. The nurse notified the provider that a different medication was needed because it was "only a matter of time" before resident-2 injured another resident. Despite the concerns, resident-2's medical record did not address staff concerns, and no new interventions were implemented.

The following day, resident-1's family reported multiple concerns to facility leadership, including that resident-2 entered resident-1's apartment, rummaged through her belongings, and frightened her. The family also reported that staff inconsistently locked the door and that resident-1 was unfamiliar with the locking mechanism and call light. Facility leadership scheduled a meeting to address these concerns five days later.

Despite reported concerns from ULPs and family, resident-1 and resident-2 medical records lacked new interventions, and no mention of locking resident-1's door.

The night before the altercation, resident-2's records indicated she entered resident-1's apartment, and staff had difficulty redirecting resident-2 to leave because she was physically combative. Later that night, resident-2 entered another resident's apartment and again resisted staff intervention.

Video footage from the day of the altercation showed resident-2 entered resident-1's apartment. Resident-1 told resident-2 to leave, guided her to the door, opened it, and watched resident-2 walk out. Resident-1 appeared to lock the door, but resident-2 returned and opened the door. Resident-2 walked toward resident-1 sitting in the chair, stood over resident-1 and yelled at her. Resident-1 told resident-2 to leave, but resident-2 refused, claimed it was her house, and used the bathroom. Resident-1 appeared visibly frustrated, rose from her chair, stood by the bathroom door, and repeatedly instructed resident-2 to leave and she would call the police if she did not leave. Resident-1 pressed her call light for staff assistance and sat down. When resident-2 finished in the bathroom, resident-1 stood up, directed her to the door, and opened it. They argued in the doorway as others passed by. Resident-2 stepped forward, and the door closed behind her. Resident-2 reached for an item before leaving the apartment and resident-1 reached back for the item. Resident-2 responded by slapping resident-1's hands at least six times then pushed resident-1 to the ground, while resident-2 simultaneously said, "I'm going to kill you if you don't quit." Resident-1 collapsed to the floor, resident-2 left the apartment; the door closed behind her. The camera captured resident-1 struggling to move and calling for staff. Approximately 13 minutes after resident-1 initially pressed her pendent, five staff members were observed in resident-1's apartment, assessed resident-1, talked among themselves, and called 911. Paramedics arrived, treated resident-1's bleeding head wound, assisted resident-1 on the stretcher, and took her to the ambulance.

Hospital records indicated that resident-1 sustained brain bleeds, a fractured right eye socket, rib fractures, and probable fractures of lumbar spine following an altercation with another resident. Resident-1's condition rapidly declined from the altercation and resident-1 died in the hospital five days later.

Resident-1's death certificate indicated the primary cause of death was from complications of multiple traumatic injuries due to assault.

During an interview, unlicensed staff reported resident-2 was aggressive and combative with others from the day she moved into the facility, and interventions were ineffective. Unlicensed staff stated they frequently updated a facility nurse by snap messages, end of shift documentation and called an on-call nurse about resident-2's behaviors including biting, slapping, punching staff and wandering into other residents' apartments. No changes were made to resident-2's plan of care.

During an interview, a facility nurse stated one of the interventions was to lock resident-1's door so wandering residents could not enter. However, there was no assessment or documentation to ensure resident-1 knew how to lock and unlock her door. In addition, it was not added to the service plan to ensure it was completed by staff. The nurse stated they were unaware of any other staff or residents being harmed by resident-2, aside from an outside agency staff person but they did not investigate that altercation because the person was not employed by the facility.

During an interview, leadership stated they were aware resident-2 had wandered into resident-1 and other residents' apartments and invaded others' space. The facility implemented appropriate interventions for safety and stated the altercation was an "unexpected" and "unfortunate event."

During an interview, resident-1's family reported that on the morning of the altercation, the family turned on the camera and saw resident-1 on the floor, bleeding and calling for help. They left home immediately and, while in route, reviewed footage showing resident-2 assaulting and threatening to kill resident-1. When the family arrived, they reported resident-1 was in the ambulance, "terrified" and repeatedly said resident-2 tried to "kill" her, repeating the same story at the hospital. Family reported they installed cameras within days of moving in because resident-2 repeatedly entered the apartment and they had other care related concerns. The family said they informed nursing and leadership multiple times of their concerns with resident-2 before the altercation occurred, because they feared something would happen.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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: No resident-1 was deceased, resident-2 was unavailable.
Family/Responsible Party interviewed: Yes, for both resident-1 and resident-2.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility called 911 when they found resident-1 injured following the altercation.
The facility worked with resident -2’s doctor for medication management. After the altercation the facility required resident -2 had one-to-one supervision from family or an outside agency until discharge.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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
Ramsey County Attorney
White Bear Lake City Attorney
White Bear Lake Police Department
Board of Executives for Long Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	C 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(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: #HL329915809C, #HL329916662M December 9, 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 103 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL329915809C, #HL329916662M Tag identification 2310, 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.	
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (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 record review, the licensee failed to ensure appropriate care and services were provided when the licensee did not implement interventions to prevent a resident-to-resident (R1 and R2) altercation. Records indicated that R2 had a history of aggressive behaviors and entered R1's apartment on multiple occasions. R1 and R2 were involved in a physical altercation, after which R1 sustained multiple brain bleeds and died. 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: R1's admission assessment dated September 12, 2025, indicated R1's diagnoses included dementia and anxiety. The assessment showed R1 required one staff member for assistance with mobility, a walker, a gait belt, safety checks, bathing, toileting, and medication administration. R2's admission assessment dated September 2,	02310		

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02310	Continued From page 2 2025, although R2 did not admit to the facility until September 5, 2025, indicated R2 had Alzheimer's disease, severe dementia with agitation, depression, and anxiety. R2 required assistance with bathing, hygiene, and medication administration. The assessment indicated R2 did not wander and remained independent with mobility. R2 experienced anxiety, especially in the evenings, was confused, and had moderately impaired decision-making and frequently exhibited fear, anger, and anxiety. R2's Individual Abuse Prevention Plan (IAPP) dated September 2, 2025, indicated R2 was vulnerable and at risk of abuse and neglect and did not pose a danger to self or others. The IAPP indicated R2 had impaired judgment, did not wander, and had no behaviors requiring intervention. R2's progress notes dated September 2, 2025, through September 19, 2025, indicated the following: -September 2, 2025, indicated R2 required intervention for anxiety, irritability or demanding behaviors and directed staff members call R2's family if they were unable to redirect behavior. - September 5, 2025, a registered nurse (RN) noted R2 was admitted to the facility, and family members would administer medication until the facility could provide medication administration. -September 6, 2025, unlicensed personnel (ULP) noted R2 was anxious and refused assistance. -September 7, 2025, ULP noted R2 was anxious and agitated, and redirection was unsuccessful. -September 8, 2025, an RN contacted R2's family to discuss behaviors of anxiety, agitation, and refusing assistance. -September 10, 2025, ULP noted R2 was wandering "a lot." RN note indicated R2 was	02310		

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02310	Continued From page 3 attempting to elope from the facility. Interventions included redirection. -September 12, 2025, ULP noted R2 wandered the hallways and required assistance with toileting. -September 15, 2025, ULP noted R2 expressed anxiety and aggression. RN indicated a family member said they would administer anti-anxiety medication to see if it would help R2. Later that evening, ULP noted they were unable to redirect R2 and that the medication the family administered was ineffective. -September 16, 2025, ULP noted R2 wandering half-naked in the hallway and crying for over 1 hour. -September 17, 2025, a nurse noted facility staff began administering R2's oral medication, but the family would be required to administer a prescription patch medication until the facility was available. -September 19, 2025, ULP noted R2 was agitated, hard to redirect, and the as needed medication was not effective. R2's 14-day nursing assessment dated September 19, 2025, indicated R2 attempted to leave the secure unit, wandered, showed anxiety, cried, and invaded others personal space. R2's interventions included redirection, as-needed medications, and music. The assessment indicated R2 was vulnerable, at risk of abuse, and did not pose a danger to the health and safety of others. The assessment indicated R2 was stable, had no change in condition and the care plan remained appropriate. In addition, the assessment noted no referrals for additional medical or cognitive evaluation were recommended. Despite R2 records indicating ULP regularly	02310		

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02310	Continued From page 4 noted R2's behavior was unmanageable, and ULP were unable to redirect R2, the licensee failed to address the concerns or implement new interventions. R2's progress notes dated September 21, 2025, through September 26, 2025, indicated the following: -September 21, 2025, ULP noted R2's medication and redirection were ineffective. -September 22, 2025, ULP noted R2 walked into R1's apartment and another resident's apartment. R2 was hard to redirect. -September 22, 2025, a RN contacted R2's primary provider and explained they were "struggling" with R2's behaviors and requested a low-dose antipsychotic medication prescribed 3 times daily because the current medication was not effective. -September 23, 2025, ULP noted R2 was crying for over an hour, exit-seeking, and as needed medication was ineffective. -September 24, 2025, ULP noted R2 was pacing, and medication was ineffective. Later, a RN noted they were summoned to assist ULP because R2 was in another resident's apartment and ULP was unable to redirect R2. R2 was resistant and kicking at the staff. The nurse called R2's family and explained that R2 could not continue to "attack staff". Later that evening, ULP contacted the after-hours nurse to report that R2 hit ULP. R2's medical records dated September 25, 2025, indicated RN notified R2's provider that R2 needed new medication because R2 was aggressive, entering other resident rooms and attacking staff and noted "It is only a matter of time before R2 hurts another resident." R2's medical records dated September 26, 2025,	02310		

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02310	Continued From page 5 indicated RN notified R2's provider that medication was ineffective and requested approval to open a capsule of medication and sprinkle it into R2's food for ease of administration. An email from R1's family to the facility leadership team, dated September 26, 2025, at 11:09 a.m., listed numerous concerns regarding R1's care. Their "biggest concern" was that R2 entered R1's apartment daily without permission, used the toilet, rummaged through R1's belongings, took items, and frightened R1. The family observed the interactions during their visits to the facility and through a webcam. Family noted that staff inconsistently locked R1's door and inquired about how the facility monitored R2's behavior, questioning whether it was simply a reality of living there. The email conveyed the family's concern, noting they often cried because they wanted R1 to be "taken care of and happy." R1's 14-day nursing assessment dated September 28, 2025, was reviewed and no changes or updates were made and indicated R1's services remained appropriate. R1's IAPP indicated R1 was at risk of abuse and neglect and did not pose a danger or safety risk to others. R1's plan required no behavior interventions. An email dated September 29, 2025, at 1:58 p.m. indicated that facility leadership had responded to R1's family email from three days earlier and scheduled an in-person meeting for October 1, 2025, at 10:00 a.m. to discuss the concerns. Despite the concerns from R1's family the medical record did not address the concerns. No	02310		

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02310	Continued From page 6 new interventions were implemented for R1 or R2. R2's progress notes dated September 28, 2025, through September 30, 2025, indicated the following: - September 28, 2025, ULP noted R2 was agitated, roaming, pacing, and crying. Medication was ineffective. Later that evening, R2 was in other residents' personal space and redirection was difficult because R2 was combative and angry. -September 29, 2025, RN noted R2 had increased aggression and crying. - September 30, 2025, ULP noted R2 was in R1's apartment and they were unable to redirect R2 due to physical aggression. Later that evening, ULP noted R2 entered another resident's apartment, was combative, swore, and tried to bit staff. R2's medical record showed interventions included redirecting behavior, offering a snack, giving as-needed medication, calling a family member, and holding hands, but ULPs consistently noted that R2's interventions were ineffective. The record did not show any additional supervision or actions by the licensee to ensure the safety of R1, R2, and other residents and staff in the memory care unit. An incident report dated October 1, 2025, indicated R2 attempted to get R2 out of her apartment and R2 pushed R1. Staff found R1 with severe bleeding from her head and unable to move. Nursing staff called 911. R1's progress notes dated October 1, 2025, indicated R2 entered R1's apartment and pushed R1, causing her to fall. Facility staff responded to	02310		

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02310	Continued From page 7 R1's call light and found R1 face down on the floor, yelling for help, with profuse head bleeding, unable to move and complaining of back pain. The nurse called 911, and paramedics transported R1 to the hospital. The notes indicated that R1's family witnessed the altercation via web cameras in the apartment and shared footage of the incident with paramedics and leadership. Video footage with continuous time stamp from R1's apartment cameras dated October 1, 2025, at 7:53 a.m. showed R2 entered R1's apartment. R1 told R2 to leave, guided her to the door, opened it, and R2 walked out. At 7:55 a.m., R1 appeared to lock the door and returned to her chair. At 7:56 a.m., R2 returned, opened the door, walked to R1 stood over her, and yelled. R1 told her to leave, but R2 refused, claimed it was her house, and used the bathroom. R1, rose from her chair, stood by the bathroom door, and repeatedly instructed R2 to leave. At 7:57 a.m., R1 pressed her call light for staff assistance and sat down. When R2 finished in the bathroom, R1 stood up, directed her to the door, and opened it. They argued in the doorway as others passed by. R2 stepped forward back into the apartment, and the door closed behind her and reached for an item. At 7:58 a.m., R1 reached back for the item and R2 slapped R1's hands at least six times then pushed R1 to the ground, while R2 simultaneously said, "I'm going to kill you if you don't quit." R1 collapsed to the floor, R2 grabbed the item and left the apartment, the door closed behind her. The camera captured R1 struggling to move and calling for staff. A staff member responded to R1's call light at 8:08 a.m., looked at R1, and walked out without saying anything. At 8:13 a.m., five staff members observed in R1's apartment. Staff assessed R1, talked among	02310		

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02310	Continued From page 8 themselves, and called 911. At 8:28 a.m., paramedics arrived, treated R1's bleeding head wound, assisted R1 on the stretcher, and took her to the ambulance. R1's hospital records dated October 1, 2025, indicated R1 arrived at the hospital with multiple injuries after another resident assaulted her in the memory care unit. The other resident broke into her apartment, pushed R1 down, and R1 struck her head. R1 reported a headache, blurry vision, and stated she was "ready to die" multiple times. R1 was diagnosed with multiple compartment hemorrhage (brain bleeds) A written report from R1's family, dated October 1, 2025, indicated R1's family checked the camera in the morning and saw R1 on the floor, surrounded by staff. The family left for the facility, reviewed the footage, and when they arrived staff called to notify them of the fall. Family informed staff that R2 caused R1's fall. Family saw R1 in the ambulance and spoke with R1. Family stated R1 was scared, repeatedly told R2 to leave, and said R2 tried to kill her. Family told R1 they knew what happened because it was on video and tried to provide comfort. R1's facility discharge summary dated October 8, 2025, indicated R1 died October 6, 2025, from a fall with head strike and laceration. The summary noted there was no evidence of abuse or concerns related to R1's vulnerability. During an interview on December 3, 2025, at 8:15 a.m., R1's family member (FM)-A reported they were present several times when R2 entered R1's apartment, which frightened R1. Concerned about R1's safety, the family installed three web cameras in the apartment to monitor the situation.	02310		

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	32991	A. BUILDING: _____ B. WING _____	C 12/09/2025

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02310	Continued From page 9 FM-A stated they raised concerns to the facility's leadership team, including a medication error, missed bathing, missing hearing aids, and other services that were not provided and noted that their biggest concern was R2's behavior. FM-A said the facility was aware that R1 feared R2, and the facility did nothing to protect R1. FM-A stated R1 went from singing "You Are My Sunshine" to passing away just five days later due to the assault. During an interview on December 9, 2025, at 11:30 a.m., the director of nursing (DON)-F reported that the facility did not complete a formal investigation of the resident-to-resident altercation because they knew what occurred from the video footage and documented the incident. DON-F reported that no other facility staff or residents were harmed by R2 however R2 injured an outside caregiver in a separate incident and the facility did not investigate because the caregiver was not employed by the facility. During an interview on December 9, 2025, at approximately 12:00 p.m. licensed assisted living director (LALD)-G said they knew R2 was entering R1 and other residents' apartments, but R2 had not shown combative behavior before the altercation. LALD-G said R2 did not target R1 because R2 did not remember her own name and would not remember the altercation. LALD-G stated the incident was an "unexpected" and "unfortunate event." During interviews on December 9, 2025, throughout the onsite investigation covering two shifts, multiple ULPs stated R2 exhibited aggressive and combative behavior, and they repeatedly reported concerns to leadership from the time of R2's admission. Staff indicated	02310		

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02310	Continued From page 10 interventions were ineffective and reported being unable to redirect R2 on multiple occasions. Two staff members reported R1 was fearful of R2 and expressed concern for R1's safety and others. Staff also reported R2 was physically combative toward them. During an interview on December 17, 2025, at 10:35 a.m., DON-F stated that the day before the altercation, all residents in memory care were assessed to determine if it was appropriate to lock their doors to prevent uninvited entry. DON-F stated R1 was determined appropriate for a key and provided one. DON-F stated there was no documentation indicating R1 was assessed or that staff was instructed to lock R1's door and was not included on the service plan which directed staff. DON-F stated R1, and family was reminded to lock the door; staff was verbally instructed to lock R1's door. DON-F stated the facility could not ensure consistent implementation locking doors in the memory care setting. DON-F stated most new residents in memory care "lashed out" at some point; that R2's behavior was neither surprising nor alarming, and part of the adjustment period, but they "bulked" up on R2's behavior interventions by providing staff with tips for anxiety, telling staff about things R2 enjoyed, like drinking soda. If the intervention failed, staff were instructed to contact R2's family to assist with de-escalation by phone or by visiting R2 at the facility. DON-F stated the facility did the best it could in the brief time it had. During an interview on January 2, 2026, at 10:37 a.m., FM-B stated they quickly determined that the facility was not the right environment. FM-B told facility leadership before admission that R2 had a history of aggressive behaviors and physical combativeness as the disease	02310		

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02310	Continued From page 11 progressed. FM-B stated it took weeks for the facility to manage and administer R2's medications which delayed care, and it was challenging because family was required to leave work to administer medications. FM-B stated R2's behavior was not new and part of the reason they sought memory care. During an interview on January 27, 2026, at 4:00 p.m., ULP-J confirmed she was heard on video after the altercation in R1's apartment, talking with peers to determine whether another resident who caused "trouble" was in R1's apartment and whether staff had locked R1's door. ULP-J confirmed the conversation on video and stated R2 was the resident she was referencing with peers. ULP-J stated they reported concerns prior to the altercation from R1 and others regarding R2 entering apartments. ULP-J reported prior to altercation, R2 was physically attacking others and had the behavior since admission to the facility. ULP-J said they locked apartment doors but observed R2 become more agitated when wandering and unable to locate an unlocked door, further agitating her. ULP-J recalled a time they found R2 in the bathroom with another resident. R2 attempted to block ULP-J entry, claiming she was helping her family member. ULP-J stated that ULPs reported concerns to nursing staff verbally and in writing, but no interventions were effective. In addition, ULP-J stated R2 bit and hit ULP-J; but the only suggestion was to give R2 ice cream or call the family because no medication was available at that time. During interview January 28, 2026, at 1:30 p.m. RN-H stated she did not recall notifying R2's provider that it was "only a matter of time" before R2 hurt another resident. RN-H stated R2 did not	02310		

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02310	Continued From page 12 hurt another resident or facility staff member that she recalled. RN-H stated it was the nurse's responsibility to update the plan of care with new interventions. RN-H did not recall any follow-up education or debrief with staff members following the altercation. During an interview, January 29, 2026, at 3:00 p.m., DON-F said R2 entered other apartments but did not harm them. R2 rummaged, or stood there, made people "weary" and sometimes pulled other residents' arms, which may have made them uncomfortable, but R2 never injured facility staff or residents. DON-F stated there were no reports of injuries because none occurred. DON-F could not recall an incident that she was summoned to assist staff because R2 refused to leave another resident ' s apartment and became combative. DON-F stated there was no further information on the previous five incidences of R2 entering other residents' apartments or personal space that the RNs noted in R2 ' s record because the incidences did not occur. During a joint interview on January 29, 2026, at approximately 3:30 p.m. with DON-F and LALD-G, DON-F stated the licensee provided staff training after the altercation however there was no corresponding documentation because it was done informally during shift change or noted in snap messages which automatically deleted after two weeks. LALD-G stated corporate directed they do not discuss, educate, or debrief the altercation with anyone due to potential legal matters. The facility's Vulnerable Adult Abuse Prevention Plan, dated October 3, 2025, required staff to protect residents from altercations with other	02310		

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02310	Continued From page 13 residents. If an altercation caused pain, injury, or mental anguish, staff were required to investigate, interview those involved, review for contributing factors or risks, and put measures in place to prevent further incidents. The plan also required staff to monitor for recurrence, review and revise policies for system changes and provide staff education/training. Time Period Correction: Seven (7) days	02310		
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: The facility failed to ensure two of two residents reviewed (R1, R2) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		