*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL336217803M
**Compliance #:** HL336213482C

**Date Concluded:** March 19, 2025

**Name, Address, and County of Licensee Investigated:**
Miakarseh House
10608 Arrowhead St NW
Coon Rapids, MN 55433
Anoka County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Lori Pokela R.N.
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 facility neglected Resident #1 and Resident #2, when Resident #2 was found touching Resident #1 in the vaginal area while under a blanket on the facility couch.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was not substantiated. Both residents were under staff supervision when the incident occurred. Although Resident #2 was found fondling Resident #1 under a blanket on a facility couch, facility staff immediately separated both residents and called administrative nursing staff and law enforcement to report the incident. Resident #1 did not want the incident reported or further investigated. Both resident responsible parties were notified, and interventions were developed to prevent further occurrence of similar incidents.

The investigator conducted interviews with the residents' responsible parties, facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator

contacted law enforcement and a hospital case worker.  The investigation included review of the resident record(s), hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement reports, and related facility policy and procedures. Also, the investigator observed the facility environment, medication administration, and staff to resident interactions.

Resident #1 resided in an assisted living facility. The resident's diagnoses included intellectual disabilities, bipolar disorder, and personality disorder. The resident's assessment indicated the resident was alert and oriented to person and place. The resident needed one-to-one staff assistance with cares, medication management, including redirection with behaviors. The resident could not be alone in the community due to vulnerabilities of exploitation by others.

Resident #2 resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder, bipolar disorder and borderline personality disorder. The resident's assessment indicated the resident was oriented to person, place, time, and situation. The resident required staff reminders for activities of daily living, medication management, and exhibited behaviors such as physical and verbal aggression.

Facility documentation indicated that while staff were cleaning up meal-time dishes, the resident's walked to the adjacent living room, where the residents could be viewed from the kitchen. Both residents were conversing and watching T.V. while staff were cleaning the kitchen. While one staff was cleaned the kitchen, another staff brought the garbage outside when both residents became quiet. Staff immediately checked on them to find the residents kissing under a blanket on the couch. When staff pulled the blanket away, Resident #2's hand was under Resident #1's dress. Staff asked Resident #2 to remove their hand and asked both residents to go to their own rooms.  Staff called administrative staff immediately after separating the residents and while speaking with the administrative staff, both residents returned to the living room. While staff was speaking with administrative staff, Resident #2 became physically aggressive towards staff and informed staff that they and Resident #1 were lovers. Resident #2 then grabbed Resident #1's breast and went to her room. Staff then contacted law enforcement who interviewed both residents and Resident #2 requested to be transported to the hospital for an evaluation. Resident #2 returned later that day.

Medical records of the residents were updated after the incident to indicate staff were to directly monitor the residents at all times and the residents were not to be alone together anywhere without a staff member present. Both resident's responsible parties were informed of the incident.

During an interview, Resident #1 stated she recalled that her and Resident #2 were sitting on the couch when Resident #2 touched her bottom area over her clothing, while the two were under a blanket. Resident #1 stated she was not O.K. with the incident, but both thought it was funny. Resident #1 stated her, and Resident #2 now have to sit at either end of the couch when both are in the living room. Resident #1 stated she felt safe at the facility.

During an interview, Resident #2 stated she did not want to talk about the incident, but stated she liked being at the facility and felt safe.

During an interview, administrative staff stated all facility staff were updated and informed of the instructions for monitoring both residents.

During an interview, Resident #1's responsible party interviewed the resident after the incident and stated Resident #1 understood the updated interventions.

During an interview, Resident #2's responsible party interviewed the resident after the incident and Resident #2 informed them that she felt safe at the facility. The responsible party stated she did not recall of Resident #2 having any previous similar incidents and there had not been any further incidents.

In conclusion, the Minnesota Department of Health determined 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.

**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-1 interviewed**: Yes.
**Vulnerable Adult-2 interviewed:** Yes.
**Responsible Party-1 interviewed**: Yes.
**Responsible Party-2 interviewed**: Yes.
**Alleged Perpetrator interviewed**: Not Applicable.

**Action taken by facility:**
The facility identified the incident immediately, separated the residents and contacted 911. New interventions were developed following the incident.

**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

You may also call 651-201-4200 to receive a copy via mail or email

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

**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 |
|---|---|---|---|
| | 33621 | A. BUILDING: _____ B. WING _____ | C 02/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MIAKARSEH HOUSE | 10608 ARROWHEAD STREET NW COON RAPIDS, MN 55433 |

| (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 |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL336213482C/#HL336217803M<br><br>On February 11, 2025, through February 24, 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 three residents receiving services under the Assisted Living license.<br><br>The following correction order is issued/orders are issued for, #HL336213482C/#HL336217803M tag identification 0130, 0800 and 1650. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 0 130 SS=D | 144G.12, Subd. 1 Application for Licensure<br><br>Each application for an assisted living facility | 0 130 | | |

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| 0 130 | Continued From page 1<br>license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including:<br>(1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility;<br>(2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director;<br>(3) the name and e-mail address of the managing agent and manager, if applicable;<br>(4) the licensed resident capacity and the license category;<br>(5) the license fee in the amount specified in section 144.122;<br>(6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant;<br>(7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182;<br>(8) documentation that the facility has liability coverage;<br>(9) a copy of the executed lease agreement between the landlord and the licensee, if applicable;<br>(10) a copy of the management agreement, if applicable;<br>(11) a copy of the operations transfer agreement or similar agreement, if applicable;<br>(12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater | 0 130 | | |

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| 0 130 | Continued From page 2<br>and that specifies their relationship with the licensee and with each other;<br>(13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of:<br>(i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act;<br>(ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service;<br>(iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service;<br>(iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or | 0 130 | | |

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| 0 130 | Continued From page 3<br>1001.201;<br>(v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;<br>(vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period;<br>(vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority;<br>(viii) any revocation or suspension of accreditation; or<br>(ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program;<br>(14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings;<br>(15) the signature of the owner of the licensee, or an authorized agent of the licensee;<br>(16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked | 0 130 | | |

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| 0 130 | Continued From page 4<br><br>under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority;<br>(17) statistical information required by the commissioner; and<br>(18) any other information required by the commissioner.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to meet the requirements of licensure when the licensed resident capacity was exceeded. The licensee's November 1, 2024 license indicated a capacity of three residents. At the time of the investigation, four residents were residing at the facility.<br><br>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).<br><br>The findings include:<br><br>On February 11, 2025, at 11:08 a.m., the investigator arrived at the licensee's entrance and while awaiting to proceed up the licensee's stairs, an individual came part-way up the lower level steps and yelled up the stairs, wearing what appeared to be lounge-sleepwear with a robe and matching pants, "Ma, are you up there?" In the entrance, there was an unused child's car seat. The investigator asked an unlicensed personnel, (ULP)-B, if a resident was living in the lower level, | 0 130 | | |

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| 0 130 | Continued From page 5<br><br>and ULP-B stated there was no resident living in the lower-level, that was a cleaning personnel. The investigator then asked why there was a child's car seat in the entrance and ULP-B stated the car seat was something she picked-up and was going to place it in her car. ULP-B then stated there were no children in the building.<br><br>The licensee's resident roster indicated three assisted living residents resided in the building.<br><br>On February 11, 2025, at 11:20 a.m., ULP-B gave the MDH investigator a tour of the building. During the tour, ULP-B stated the lower level was for staff members only. The investigator observed the same individual (who yelled up the stairs) in the lower level, but was now wearing a coat, boots and going upstairs. The investigator asked ULP-B the name of the person who ULP-B identified in the morning as a cleaning personnel. ULP-B directed the investigator to ask the licensed assisted living director, who is also the clinical nursing director registered nurse (LALD)-A/RN who that individual was. The investigator also observed several personal items in a lower level nursing office, including a child's toilet seat, a bathroom and living area. There was one room in the lower level that was locked and ULP-B stated she did not have a key to open the door.<br><br>On February 11, 2025, at 12:07 p.m., LALD-A arrived at the licensee with a child, whom she stated was her grandchild. After introduction, the investigator asked LALD-A if she had a key to open the locked room downstairs. LALD-A stated the key was at home and she did not have a key to open the locked door at the licensee.<br><br>During an interview on February 11, 2025, at | 0 130 | | |

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| 0 130 | Continued From page 6<br><br>12:25 p.m., the investigator asked LALD-A who the woman was downstairs that was witnessed upon the investigator's arrival. LALD-A stated the woman was her daughter, the grandchild's mother, who was visiting the licensee today. LALD-A stated the building used to be her and the daughter's home before it was licensed as an assisted living facility. LALD-A stated there continues to be personal items of LALD-A and the daughter's in the lower level of the licensee.<br><br>During an interview on February 11, 2025, at 1:50 p.m. R1 stated that the LALD-A's daughter lives downstairs.<br><br>During an interview on February 11, 2025, at 2:21 p.m. R3 stated the LALD-A's daughter and the daughter's son have lived downstairs for approximately one month.<br><br>Minnesota Assisted Living Statutes 144G.08 definitions indicated:<br>- Subd. 2. Adult - "Adult" means a natural person who has attained the age of eighteen years.<br>- Subd. 5. Assisted living contract - "Assisted living contract" means the legal agreement between a resident and an assisted living licensee for housing, and if applicable, assisted living services;"<br>- Subd. 7. Assisted living licensee - "Assisted living licensee" means a licensee that provides sleeping accommodations and assisted living services to one or more adults. Refer to clauses 1-15 for exclusions.<br>- Subd. 59. Resident. - "Resident" means an adult living in an assisted living licensee who has executed an assisted living contract.<br><br>No further information was provided. | 0 130 | | |

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| 0 130 | Continued From page 7<br>TIME PERIOD FOR CORRECTION: Two (2) Days. | 0 130 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to ensure the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect more than a limited number of residents, staff, and visitors.<br><br>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 the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On February 11, 2025, at 1:40 p.m., during a tour | 0 800 | | |

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| 0 800 | Continued From page 8<br><br>of the licensee with the licensed assisted living director, who is also the clinical nursing director registered nurse (RN), (LALD)-A, it was observed that there was a sliding door installed bewtween the basement and the stairs leading to the main floor level of the home. There were two locks and hardware on the sliding door installed between the basement and the stairs leading to the main floor level of the home. The key locked faced the upper level of the licensee, while the turning component of the hardware faced the lower level of the licensee. A bolt lock was observed at the top of this same door toward the lower level rooms of the licensee. A key-only lock was installed on the stair side of the sliding door. On the basement side of the sliding door, a sliding bolt-style lock was installed near the top of the door with the bracket installed into the door jamb. The use of this type of door-locking hardware would limit the ability of occupants to safely exit the building in the event of an emergency. Door latching hardware is required to be located not higher than 48" from the floor.<br><br>During an interview on February 11, 2025 at 1:40 p.m., LALD-A stated the locks were also noted on the licensee's last survey and did not work.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 01650 SS=D | 144G.70 Subd. 4 (f) Service plan, implementation and revisions to<br><br>(f) The service plan must include:<br>(1) a description of the services to be provided, the fees for services, and the frequency of each | 01650 | | |

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| 01650 | Continued From page 9<br><br>service, according to the resident's current assessment and resident preferences;<br>(2) the identification of staff or categories of staff who will provide the services;<br>(3) the schedule and methods of monitoring assessments of the resident;<br>(4) the schedule and methods of monitoring staff providing services; and<br>(5) a contingency plan that includes:<br>(i) the action to be taken if the scheduled service cannot be provided;<br>(ii) information and a method to contact the facility;<br>(iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and<br>(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.<br><br>This MN Requirement is not met as evidenced by:<br>Based on record review and interview, the licensee failed to ensure the service plan included the required content for two of two residents (R1 and R2) reviewed.<br><br>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 | 01650 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 33621 | A. BUILDING: _____ B. WING _____ | C 02/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MIAKARSEH HOUSE | 10608 ARROWHEAD STREET NW COON RAPIDS, MN 55433 |

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|---|---|---|---|---|
| 01650 | Continued From page 10<br><br>a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1:<br><br>R1 began services on February 6, 2020. R1's diagnoses included moderate intellectual disabilities, bipolar disorder, and borderline personality disorder.<br><br>R1's 90-day nursing assessment dated, December 26, 2024, indicted R1 was alert and oriented to person and place. R1 received assistance with, toileting, grooming, medication management and behavior monitoring.<br><br>R1's service plan dated February 26, 2024, lacked the following content:<br>-a description of R1's services and service details.<br>-a description of the fees for services.<br><br>R2:<br><br>R2 began services on June 2, 2018. R2's diagnosis included bipolar disorder, borderline personality disorder and schizoaffective disorder.<br><br>R2's 90-day nursing assessment dated, December 22, 2024, indicated R2 was oriented to person, place, time, and situation. R2 received staff assistance with activities of daily living such as toileting, grooming, medication management and behavior monitoring.<br><br>R2's service plan dated June 6, 2021, lacked the following content:<br>-a description of R1's services and service | 01650 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 01650 | Continued From page 11<br>details.<br>-a description of the fees for services.<br><br>During an interview on February 20, 2025 at 4:10 p.m. the licensed assisted living director(LALD)-A, who is also the clinical nursing director registered nurse (RN), acknowledged the lack of required content and stated, "I reached out to the consultant company and a new contract is being developed.<br><br>Policy:<br><br>The licensee provided Minnesota Home Care Bill of Rights for Assisted Living Clients Statute 144G.4791 Sub. 1 , undated, indicated under (1) A person who receives home care services has the right to receive written information about rights before receiving services.. (3) A person who receives home care services has these rights to told before receiving services the type and disciplines of staff who will be providing the services, the frequency of visits proposed to be furnished, other choices that are available for addressing home care needs, and the potential consequences of refusing these services.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01650 | | |