Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL343608782M
Compliance #: HL343601942C

Date Concluded: April 30, 2026

Name, Address, and County of Licensee Investigated:
Capital Home Health Care LLC
3516 73rd Avenue
Brooklyn Park, MN, 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
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 a resident when they failed to provide supervision. Facility staff found the resident unresponsive and all life saving measures were ineffective.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident had an extensive history of using street drugs (fentanyl, methamphetamine) which resulted in legal requirements for treatment. His legal commitment requirements included abstinence from street drugs or drugs not prescribed to him. Failure to comply with the commitment requirements would have required the resident to return to a more restrictive treatment program. The facility received this information prior to admitting him and determined they could provide the services he required. Three months after the resident admitted to the facility, he overdosed on street drugs, required lifesaving measures, and recovered. The facility failed to reassess the resident after the overdose with evaluation of current measures to keep him safe for effectiveness and implement increased

monitoring with specific instructions for staff to follow when the resident used drugs. He continued to use street drugs and died from a drug overdose three months after his first overdose at the facility. Multiple systemic facility failures contributed to the lack of oversight, supervision and attempts to comply with the resident's legal requirements.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a case worker. The investigation included review of the resident records, death record, hospital records, facility incident reports, personnel files, court documents, law enforcement reports, and related facility policy and procedures. Also, the investigator toured the facility and observed staffing levels and documentation systems.

The resident resided in an assisted living facility. The resident's diagnoses included opioid (fentanyl) dependency. The resident resided in a basement bedroom of the facility. The resident's service plan included assistance with behavior management.

Prior to the resident's admission to the facility, the resident lived at an intensive residential treatment service (IRTS) facility. The resident's mental health commitment and treatment program discharge orders indicated conditions of discharge required the resident to take his medications as prescribed, maintain safety and well-being, abstain from alcohol, illegal drugs and medications not prescribed to him. Violation of the terms required the resident to return to a more restrictive setting if he was not in agreement with treatment or if there was a concern about his safety due to mental illness and/or consequences of substance abuse. The resident remained on those requirements through his duration at the facility.

During an interview, a case manager said the resident had an extensive history of drug use (including fentanyl) and multiple interactions with law enforcement for criminal acts, mostly drug related. The case manager said the court system determined the resident required a "commitment" (mandatory treatment). The case manager said when the resident was ready to discharge from the IRTS facility, she met with the leadership from the assisted living facility to discuss his needs. The case manager said she gave the facility leadership the resident's court documents, hospital records, and IRTS records. The case manager said the facility accepted the resident for admission.

The resident's admission nursing assessment indicated the resident had a history of opioid-induced psychotic disorder (severe mental health condition) with hallucinations and psychoactive substance abuse (compulsion to take drugs). The resident lived at an IRTS facility before admission. The assessment indicated the resident did not have a history of elopement attempts, however, also indicated the resident had a history of elopement and leaving the property. Interventions to manage elopement included staff to remind him to let them know when he was leaving, remind him to charge his cellphone, and make sure windows were secured to provide a safe environment. The assessment indicated the resident used "street drugs," had overdosed with unknown drugs and required hospitalization. Interventions to

manage his drug use included safety checks and report unusual behaviors. The assessment failed to identify the frequency of safety checks or specify the resident's signs and symptoms of drug use for staff to monitor and report. Although the assessment indicated nurse completed the assessment in person, the assessment also included the nurse's handwritten signature with the electronic date after the investigator's onsite visit to the facility.

The resident's care plan indicated he had a history of elopements from the facility but failed to indicate if he should not leave the facility unattended. The care plan lacked indication the actions staff should take upon his return to the facility if he left unattended. The care plan failed to identify the frequency of safety checks.

The resident's individual abuse prevention plan (IAPP) indicated the resident used street drugs, and overdosed from using them. The IAPP indicated the resident required safety checks, but failed to identify the frequency of safety checks. The IAPP failed to identify the resident's signs of drug use and specific actions for staff to take when the resident used drugs.

The resident's service plan indicated the facility would provide various behavior management, none of which identified to monitor for drug use. The behavior management services were scheduled two to three times per day (once per shift). The service plan lacked a service for safety checks.

An incident report approximately three months after admission, indicated staff members found the resident unconscious in his bedroom and called emergency services (911). The report indicated the resident did not have a pulse and required cardiopulmonary resuscitation (CPR). The resident required Narcan (medication used to reverse opioid overdose). The resident was hospitalized.

Law enforcement records indicated staff told law enforcement they gave the resident two shots of Narcan, but they were unsure if they did it correctly. Law enforcement found substances consistent with street drugs and drug paraphernalia in the resident's room. Additional records indicated the substances were fentanyl, methamphetamine, marijuana, and olanzapine (anti-psychotic drug).

Hospital records indicated the resident had a fentanyl overdose and acute (sudden) hypoxic respiratory failure (low oxygen levels). The resident also had lung injury/pneumonia, and pulmonary edema (fluid in lungs). Hospital records indicated the resident had a history of multiple incidences of drug overdoses from fentanyl. The records indicated the resident left the hospital against medical advice and returned to the licensee.

The resident's record lacked a nursing assessment after the resident's drug overdose and hospitalization and therefore no new interventions to try and prevent another overdose were implemented. The resident's service plan remained unchanged and had no services for safety checks.

Law enforcement records indicated 13 days later, the facility staff contacted law enforcement because they found a baggie of white substance in the resident's room. The manager stated he completed periodic room checks. The resident said the substance was from another individual who visited him the day prior. The manager told law enforcement whenever the resident was with that individual he came back to the facility "high." Law enforcement determined the substance was a substantial amount of fentanyl.

A week later, the nurse completed a routine 90 day assessment. The assessment indicated the resident had an emergency room visit due to a drug overdose and the physician prescribed Narcan. The resident's safety section, vulnerability section and cognitive/behavior sections of the assessment had the same verbatim language as the admission assessment. The assessment failed to evaluate current interventions for effectiveness nor identify new interventions to implement to try to prevent the resident's drug use when the resident's commitment order required him to abstain from drug use.

Service delivery records and progress notes reviewed indicated an additional behavior management service, for self-injurious behavior was added to monitor three times a day, once per shift.

Progress notes reviewed two and a half months prior to the resident's death indicated he had no behaviors, including elopement and self-injurious behavior. Which was inconsistent with an incident report and the facility staff interviews regarding his behaviors.

An incident report one month after the 90 day assessment, indicated the resident eloped from the facility when he got into someone's car and they drove off. The report lacked indication how long the resident was gone or when he returned. The progress notes from this date failed to included any notes during the shift of the elopement. The evening shift notes failed to have any information about the resident's elopement or follow up on the resident's status.

An incident report two weeks later indicated the manager called an ambulance because the resident had chest pain. The report lacked further information about what occurred. The progress notes lacked any information about this incident.

The resident record lacked nursing follow up on the resident's elopement and chest pain needing medical response. The facility failed to provide any records or documentation of communication with the resident's physician after his overdose, about any drug use or efforts made to comply with his legal requirements of moving the resident back to a more restrictive facility due to his non-compliance with abstaining from drug use.

An incident report one month later, indicated staff found the resident in his bedroom without a pulse and staff started CPR. Emergency responders determined the resident was deceased.

Law enforcement records indicated the manager told them he checked on the resident about an hour before the other staff member found him and he was breathing. Law enforcement records indicated the resident's body did not appear consistent with the managers timeline because the resident's body had significant rigor mortis (body stiffness which occurs six to twelve hours after death). Law enforcement records indicated the resident had burnt tinfoil with white-like substance inside, along with a straw on his bed. Law enforcement records indicated they asked the manager for the facility video footage; however, the records lacked any indication the manager provided video footage.

The medical examiner report indicated the resident died due to an overdose of fentanyl and methamphetamines.

During an interview, a case manager said after admission, the resident overdosed on drugs, so she met with facility leadership again to discuss the resident's care needs which included closer supervision. The case manager said facility staff also found drugs (fentanyl) in the resident's room.

During an interview, a staff member said the resident lived in a basement bedroom at the facility. The staff member said the resident frequently eloped the facility by a climbing out a basement window. The staff member said he thought the resident got substances from the individuals who lived across the street, so he went over the facility across the street to speak to their staff. The staff member said he worked the evening before the resident died, and nothing seemed unusual about the resident's behavior. The staff member said the resident left the facility for short periods, but always returned. The staff member said he checked on the resident hourly during his shift. The resident was sleeping in his bed when he left the facility at the end of his shift.

During an interview, a facility manager said the resident lived at an IRTS facility, then left and stayed with a family member prior to admission. The manager said he met with the resident and his case manager prior to accepting him for admission. The manager said the resident required staff to observe and re-direct his behaviors, give him medications, and take him to medical appointments. The manager said initially the resident could leave the facility unattended. The manager said one night the resident returned late in the night/early morning and went downstairs to his bedroom. Staff found him unconscious, lying on the floor. The manager said they gave the resident Narcan and called emergency services (911). The manager said the resident required life saving measures including CPR and hospitalization. The manager said the resident overdosed on fentanyl, but he returned to the facility. The manager said he met with the resident and his case manager after this incident and convinced the resident not to leave the facility unattended. The manager said the resident did not receive drug treatment; however, he did complete the required assessment, so they were in the process of looking for his treatment options. The manager said he worked during the night prior to the resident's death. The manager said he took the resident to a local gas station late in the night because the resident wanted to buy snacks. The manager said he did not go into the store with him, but

watched him the whole time and could see him buy his snacks. The manager said he took the resident back to the facility and checked on him approximately three hours later and found him sleeping in his bed. The manager said he “peeked in” on the resident about two hours later and saw the same thing. An hour later, another staff member entered the facility and checked on the resident and found him unresponsive. The manager said he was still at the facility, so he went downstairs. The manager said the resident was unconscious, so they called 911 and followed their instructions. The manager said he gave the resident Narcan and started CPR. The manager said when 911 responders arrived they were unable to revive the resident and determined he was deceased.

The facility nurse declined the interview but had stated she did not complete any additional nursing assessments after the 90 day assessment.

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. Deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility called 911 then they found him unresponsive and attempted life saving measures.

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
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34360	A. BUILDING: _____ B. WING _____	C 03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITAL HOME HEALTH CARE LLC	3516 73RD AVENUE BROOKLYN CENTER, MN 55429

(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: HL343601942C/HL343608782M HL343606684C/HL343601721M HL343606674C On March 31, 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 four residents receiving services under the provider's Assisted Living license. The following correction orders are issued for HL343601942C/HL343608782M, tag identification 1620, 2360. No correction orders are issued for HL343606684C/HL343601721M. No correction orders are issued for HL343606674C.	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. 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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01620	Continued From page 1	01620		
01620 SS=J	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620		

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01620	Continued From page 2 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct change of condition nursing assessments to address drug seeking behavior and street drug overdoses for one of one resident (R1) with records reviewed. Because of this failure, the licensee did not implement further services to identify and mitigate the risks of R1's behavior. R1 died from a drug overdose (fentanyl, and methamphetamine). This practice resulted in a level four violation (a violation that harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury 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's discharge orders from a state operated treatment program dated November 6, 2024, indicated R1 was on a commitment order as the result of several criminal charges that led to a	01620		

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01620	Continued From page 3 Rule 20 determination (time served can be done in a mental health treatment facility) and found incompetent. Conditions of discharge required R1 to take his medications as prescribed, maintain safety and well being, abstain from alcohol, illegal drugs and medications not prescribed to him. Violation of the terms requires a more restrictive settings and not in agreement with treatment or if there was a concern about R1's safety due to mental illness and/or consequences of substance abuse. The provisional discharge may be extended by the court. Court records dated March 4, 2025, indicated after a six month review, a law judge determined to continued R1's commitment order with an expiration date of August 25, 2025. R1 admitted into the licensee on June 16, 2025 for diagnoses including opioid dependence, major depressive disorder, and generalized anxiety disorder. R1's service plan dated June 17, 2025, (addendum to Contract) indicated R1 required behavior management for agitation, socialization, anxiety, orientation, psychosis, wandering, aggression, property destruction, repetitive behaviors, and verbal aggression. The service plan indicated the frequency for these services was two to three times per day. The service plan lacked indication or specification of services to manage drug seeking behavior and/or street drug use. No further service plan addendums provided. R1's admission nursing assessment dated June 17, 2025, indicated R1 admitted from an intensive residential treatment services (IRTS) facility. The	01620		

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01620	Continued From page 4 nursing assessment indicated R1's history included opioid-induced psychotic disorder with hallucinations, psychoactive substance abuse, and generalized anxiety disorder. The assessment indicated R1 did not have a history of elopement attempts, however, the assessment also indicated R1 had a history of elopement and leaving the property. Interventions to manage elopement included for staff to remind him to let them know when he was leaving, remind him to charge his cellphone, and make sure windows are secured to provide a safe environment, but do not disturb him when he was listening to music. The assessment indicated R1 used "street drugs" and had overdosed with unknown drugs and required hospitalization. Interventions to manage his drug use included safety checks. The assessment failed to identify the frequency of safety checks. Although the assessment indicated registered nurse (RN)-D completed the assessment in person, the assessment also included RN-D's handwritten signature with the electronic date of April 9, 2026. Court records dated August 21, 2025, indicated a law judge determined R1 was a chemically dependent person. The record indicated R1 was "likely to attempt to physically harm himself or others" and risk for self neglect with failing to provide himself with food, clothing, shelter and medical care. The court extended the terms of his commitment until August 21, 2026. Incident report dated September 5, 2025, at 4:42 a.m., indicated staff members found R1 unconscious in his bedroom and called emergency services (911). The report indicated R1 did not have a pulse and required cardiopulmonary resuscitation (CPR). R1 required Narcan (medication used to reverse	01620		

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01620	Continued From page 5 opioid overdose). R1 was hospitalized. Law enforcement records dated September 5, 2025, indicated R1 was in his downstairs bedroom when law enforcement arrived. R1 was unconscious and required CPR. Licensee staff told law enforcement they gave R1 two shots of Narcan, but they were unsure they did it correctly. Law enforcement found substances consistent with street drugs and drug paraphernalia in R1's room. Additional records indicated the substances were fentanyl, methamphetamine, marijuana, and olanzapine (anti-psychotic drug). Hospital records dated September 5, 2025, indicated R1 had a fentanyl overdose and acute (sudden) hypoxic respiratory failure (low oxygen levels). R1 also had lung injury/pneumonia, and pulmonary edema (fluid in lungs). Hospital records indicated R1's medical diagnoses included schizophrenia, bipolar disorder, polysubstance use disorder, and multiple incidences of drug overdoses from fentanyl. The records indicated R1 left the hospital against medical advice and returned to the licensee. R1's record lacked a nursing assessment following his hospitalization and drug overdose. Law enforcement records dated September 18, 2025, indicated the licensee contacted law enforcement because they found a baggie of white substance in R1's room. Law enforcement went to the facility and licensed assisted living director (LALD)-A told them he completed "periodic room checks" and found the substance in R1's room. LALD-A told law enforcement R1 had a prior drug overdose. The records indicated R1 told them the substance was from another individual who visited with him previously in the	01620		

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01620	Continued From page 6 day. LALD-Atold officers whenever R1 was with this individual, he came back "high." Law enforcement records indicated they determined the substance was a substantial amount (two grams) of fentanyl. Nursing assessment dated September 25, 2025, indicated RN-D completed a routine (required) 90-day nursing assessment. The assessment contained a section titled, "Summary" which indicated R1 had an emergency room visit due to a drug overdose. The summary indicated physician's prescribed Narcan. The assessment indicated RN-D made no further changes to R1's elopement, or drug use interventions. This assessment failed to identify diagnoses as indicated in the hospital records. This assessment failed to identify R1 had a court appointed commitment. The nursing assessment failed to include updated, person centered, individualized interventions to address R1's increasing drug seeking behavior and elopements. Incident report dated October 28, 2025, indicated R1 eloped. The report indicated R1 got into someone's car, and they drove off. The incident report indicated unlicensed personnel (ULP)-B told M-A about the elopement. The incident report lacked further details about R1's elopement length or when he returned. Incident report dated November 15, 2025, at 1:50 a.m., indicated LALD-A called an ambulance because R1 had chest pain. The report lacked further information regarding what occurred. R1's record lacked a nursing assessment following R1's elopement and for reported chest pain needing medical response.	01620		

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01620	Continued From page 7 Incident report dated December 14, 2025, at 8:10 a.m., indicated facility staff found R1 in his bedroom. R1 did not have a pulse and staff initiated CPR. The report indicated emergency responders determined R1 was deceased. Law enforcement records dated December 14, 2025, indicated R1 was in his downstairs basement bedroom when they arrived. The records indicated R1's body was in rigor mortis (body stiffening usually around six to twelve hours after death). Law enforcement found a burnt tinfoil with white substance and other drug paraphernalia on R1's bed. On April 9, 2026, at 10:31 a.m., case manager (CM)-F said R1 had an extensive history of drug use (including fentanyl) and multiple interactions with law enforcement for criminal acts, mostly drug related. CM-F said the court system determined R1 required a "commitment" (mandatory treatment). CM-F said when R1 was ready to discharge from the IRTS facility, she met with leadership from the assisted living facility to discuss his needs. CM-F said she gave the facility leadership R1's court documents, hospital records, and IRTS records. CM-F said the facility accepted him for admission. After admission, R1 overdosed on drugs, so she met with facility leadership again to discuss his needs. CM-F said they discussed R1 needed closer supervision. CM-F said facility staff also found drugs (fentanyl) in R1's room. On April 9, 2026, at 12:04 p.m., ULP-B said R1's behavior escalated about one month after admission. R1 frequently eloped out of a window in the basement and "ran away." ULP-B said he thought R1 got substances (drugs) from	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34360	A. BUILDING: _____ B. WING _____	C 03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 8 individuals who lived across the street, so he went over to the facility across the street and spoke to their staff about it. ULP-B said he completed hourly safety checks after R1's initial drug overdose at the facility. ULP-B said he told RN-D about R1's behaviors and received verbal instructions to "watch" him and to call 911 if needed. On April 14, 2026, at 10:53 a.m., RN-D said she completed R1's nursing admission assessment on June 17, 2025, his required 14 day assessment on July 1, 2025, and his 90-day assessment on September 25, 2025. RN-D said she did not complete any additional nursing assessments prior to R1's death. The licensee's policy titled, Initial and On-going Nursing Assessment of Resident's Under the Comprehensive Licensed Agency, no date, indicated the licensee registered nurse would complete comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required including change of condition. TIME PERIOD FOR CORRECTION: SEVEN (7) DAYS.	01620		
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 one of one resident(s) reviewed (R1) was free from maltreatment.	02360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02360	Continued From page 9 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		