Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL358675582M
Compliance #: HL358677328C

Date Concluded: October 15, 2025

Name, Address, and County of Licensee Investigated:
Noah Assisting Living
5100 Xerxes Avenue North
Minneapolis, MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, 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 the resident when the facility failed to provide proper shelter and supervision for the resident as required when facility staff left the facility with the other facility residents on an outing and left the resident unsupervised and locked out of the facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident was legally blind and declined participating in facility outings. When the resident declined an outing, the facility staff either made the resident leave the facility or had him wait outside as the facility staff locked the doors while they were on the outing with other residents, leaving no staff home for the resident to remain home. On one occasion, the resident's community support staff found him outside, locked out of the facility.

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, facility incident reports, staff schedules, facility activity schedules, and related facility policy and procedures. Also, the investigator observed resident and staff interactions while on site.

The resident resided in an assisted living facility. The resident's diagnoses included generalized anxiety disorder and legal blindness. The resident's service plan included assistance with incontinence care, grooming, social time, behavior management, meal assistance, and safety checks. The resident's assessment indicated the resident walked independently with a cane and participated in activities without assistance. The resident was at risk to be abused by others and had history of verbal and physical aggression with property damage. The assessment identified the resident was alert and oriented to person, place, and time.

The resident's activity assessment indicated his interests included the outdoors, fishing, basketball, singing and playing music.

During an interview, the resident stated the facility did outings such as going to a movie, out to eat, or to the state fair. The resident stated he did not have to go if he did not want to but had to find somewhere else to go if everyone else went. The resident stated there was a time the staff and residents left the facility around 4:00 p.m. for a dinner outing that he did not want to go on. He had to leave the facility while the staff were gone and when he returned to the facility around 8:00 p.m. the door was locked. The resident stated he did not realize the outing was dinner and a movie, so he waited outside on the deck for about an hour before they returned. The resident stated there was another time he stayed behind when everyone else went on a walk, so he just sat outside because they locked the door every time they left. Another occasion, during the spring, the resident stated it was colder outside, and him and another resident had to wait outside on the porch for about an hour until staff returned because they did not attend the outing. The resident stated he never missed his medications due to being locked out of the facility, and he was lucky he did not have to go to the bathroom during that time. The resident stated if he had needed to go to the bathroom, he would have walked six houses down the street to his friend's house to use the bathroom. The resident stated he did not understand why the facility would not have a staff member stay behind with anyone who did not want to go on the outing.

During an interview, a community support staff member (CSS) stated he schedule an appointment with the client to meet at the facility to complete some annually required paperwork. The CSS stated he spoke to the resident on the phone prior to his arrival to let the resident know he was on his way. When he arrived at the facility, he observed the resident sitting outside on the facility porch, shirtless. The CSS asked the resident if they could go inside to complete the paperwork, and the resident told the CSS they could not because the door was locked. The CSS stated he checked the door, and it was locked. The CSS stated he asked the resident why he was locked outside and the resident told him it was because the staff member

took the residents out for lunch, and he did not want to go due to feeling uncomfortable in public due to his blindness. The CSS stated the resident told him he did not have to go on the outings if he did not want to, but he was not able to go in the facility until they got back. The CSS stated it was a warm day, and he did not recall if the resident had water or anything else to drink. The CSS stated the resident told him he would urinate in the alley if he needed to go to the bathroom. The CSS stated the staff and other facility residents returned to the facility about 30 minutes after he had arrived. The CSS stated he did not speak to the staff when they returned. He left after he and the resident completed the paperwork. The CSS stated he did not believe leaving the resident behind and locked out of the facility was a safe option for the resident, and he did not understand why they did not give the resident a key or have a staff member stay behind with him.

A facility activities schedule indicated “group exercises” scheduled the day of the CSS arrived. A lunch outing was not noted on the activities schedule.

A facility provided record of a staff meeting dated seven days prior to the reported incident indicated staff were educated to complete wellness checks on residents every two hours to ensure the resident is accounted for and for an assessment of their overall condition. The record indicated staff were educated the wellness checks should involve brief interactions with every resident to observe their well-being, monitor for signs of distress or unusual behavior, and ensure their surroundings are safe. The record indicated staff were educated when a resident was outside, they required careful monitoring to ensure the resident’s safety. The record lacked documentation of the staff members who attended the staff meeting.

The facility did not provide any incident reports related to the resident being locked out of the facility and left unsupervised.

The resident’s progress notes lacked any documentation of an incident of the resident declining to attend a facility outing.

A facility staffing policy indicated the facility staffing plan was prepared by the nurse supervisor and considered the number of care givers to meet the residents’ needs throughout the day and night. The policy indicated residents are provided with a means to request assistance for health and safety needs 24 hours a day, seven days a week.

During an interview, the house manager (HM) stated all residents required supervision, and staff completed safety checks every one to two hours. The HM stated the facility did resident outings every one to one and a half weeks and they each lasted a couple hours. The HM stated all residents were invited to attend outings, but it is the resident’s right to decline if they do not want to go. The HM stated if there is a resident who does not want to go, the staff might reschedule the outing, so no resident is left alone. The HM denied locking the resident out of the facility. The HM stated there had been a couple times the resident did not want to attend

the facility outing, so they planned for him to go somewhere else while the staff member was with the other residents on the outing.

During an interview, the licensed assisted living director (LALD) stated all residents are invited to activities and outings are done weekly. The LALD stated they plan who is available on the staff schedule to take residents out and who can stay back with any residents who do not want to go out. The LALD stated she did not recall a time when the resident did not want to go on an outing.

The resident's family member did not respond to request for interview.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The facility did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility directed an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility failed to provide adequate staffing levels.

The facility failed to follow the facility directive and/or policies and procedures.

(3) The facility failed to follow professional standards and/or exercise professional judgement.

The facility failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No, did not respond to request for interview.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
No action taken.

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
Minneapolis City Attorney
Minneapolis Police Department
Minnesota 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
	35867	A. BUILDING: _____ B. WING _____	C 09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOAH ASSISTING LIVING INC	5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430

(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: HL358677328C/HL358675582M On September 3, 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 provider's Assisted Living license. The following correction orders are issued for HL358677328C/HL358675582M, tag identification 470, 490, 2360.	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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to ensure sufficient staffing at all times to cover 24 hours per day, seven days a week to all residents for 1 of 1 residents (R1) reviewed. Facility staff took residents to an activity away from the facility and left R1 alone at the facility with no staff. This deficient practice	0 470		

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0 470	Continued From page 2 had the potential for affect all residents. 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). The findings include: R1's diagnosis included generalized anxiety disorder and legal blindness. R1's service plan dated August 20, 2025, indicated R1 received behavior management, meals, and safety check services. A facility staff schedule dated May 21, 2025, indicated manager (M)-B was scheduled to work 9:00 a.m. to 5:00 p.m., a registered nurse was scheduled to work 9:00 a.m. to 4:00 p.m., and an unlicensed personnel (ULP) was scheduled to work 10:00 a.m. to 10:00 p.m. on the day of the reported incident. A licensee provided document, undated, titled June Activity Calendar, indicated Group Exercise was the scheduled activity on the day of the reported incident. During an interview on September 3, 2025, at 11:40 a.m., R1 stated when there was a facility outing that he did not want to go to, he stayed behind. R1 stated the staff left with the other residents for the outing and locked the door of the facility. R1 stated he had to wait outside or go	0 470		

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0 470	Continued From page 3 to a friend's house because the staff went with the other residents and locked the door of the facility while they were gone. R1 stated he did not understand why there was not a staff member who stayed behind if he did not want to go on the outing. R1 stated there was another time in the spring when it was colder out, that he and another resident both had to wait outside on the porch for about an hour until staff returned to the facility. During an interview on September 10, 2025, M-B stated the facility was staffed with one ULP and sometimes she, the director, or the nurse is the second caregiver. M-B stated staff are required to check on the resident's every one to two hours, and all facility residents required supervision. M-B stated if a resident did not want to go on an outing, the outing might be rescheduled, and no resident was ever left alone. M-B denied a resident was ever left at the facility locked outside. M-B stated it was not acceptable to leave a resident alone locked outside of the facility. During an interview on September 12, 2025, at 3:00 p.m., licensed assisted living director (LALD)-D stated there are three ULPs for the three shifts in each day, plus M-B, herself, and a nurse who comes when they need to. LALD-D stated staff should perform safety checks on the residents every hour, and all the residents required supervision. LALD-D stated when organizing an outing, they try to see who is on the schedule to see who is available to take the residents out, and who can stay back with them. LALD-D stated a resident has never been left behind and locked out of the facility, and they would never do that. LALD-D stated R1 required	0 470		

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0 470	Continued From page 4 supervision, and she did not recall any time R1 did not attend a facility outing. During an interview on September 15, 2025, at 11:00 a.m., a community support staff (CSS)-E stated he had arranged to meet with R1 at the facility to complete some paperwork. CSS-E stated upon arrival to the facility, he noted R1 outside on the facility porch. CSS-E stated he asked R1 to go inside to complete the paperwork, and R1 told him they could not, because the door was locked. CSS-E stated he attempted to open the door to the facility and observed the door was in fact locked, and no staff were present at the facility. CSS-E stated R1 told him he did not specifically know when the staff would be back. CSS-E stated he was concerned there was not a staff member at the facility to stay with the resident when he did not want to go on the outing. The licensee-provided policy titled Staffing, dated August 1, 2021, indicated the staffing plan considers the number of care staff to meet the residents' needs throughout the day and night. The policy indicated residents are provided with a means to request assistance for health and safety needs 24 hours a day, seven days a week. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 490 SS=F	144G.41 Subdivision 1b Minimum requirements; other required services All assisted living facilities must offer to provide or make available the following services to residents: (1) weekly housekeeping;	0 490		

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0 490	Continued From page 5 (2) weekly laundry service; (3) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (4) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (5) provide culturally sensitive programs; and (6) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide activities based on individual preferences for a resident that was blind to meet the physical needs and create opportunity for participation in the community for 1 of 1 residents (R1) reviewed. This deficient practice had the potential to affect all residents. 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	0 490		

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0 490	Continued From page 6 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). The findings include: R1's diagnosis includes generalized anxiety disorder and legal blindness. R1's service plan dated August 20, 2025, indicated R1 received behavior management, meal, and safety check services. A report, dated June 6, 2025, indicated R1 stated he did not want to join the staff and other residents on a lunch outing, as he was often uncomfortable going out in public due to his blindness. The report indicated R1 instead chose to sit outside on the porch until the facility staff and resident's returned. A licensee provided document, undated, titled June Activity Calendar, indicated Group Exercise as the scheduled activity on the day of the reported incident. The calendar did not indicate any group outings scheduled. R1's assessment dated May 5, 2025, indicated R1's interests included the outdoors, fishing, basketball, singing, and playing music. The assessment indicated R1 was independent with activity participation and required reminders to attend activities. The assessment indicated engaging in sports and outdoor activities would cater to R1's emotional and social needs. R1 required assistance with arranging transportation. R1 was at risk for abuse related to his visual impairment. The assessment lacked documentation of interventions related to ensuring the psychosocial needs of R1 were met	0 490		

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0 490	Continued From page 7 through activities he preferred, and those he could participate in despite his visual impairment. R1's individual abuse prevention plan (IAPP) dated August 12, 2025, indicated R1 required assistance with arranging transportation, and relied on the shoulder of a guide to navigate the city. R1's progress notes dated June 1, 2025, through September 3, 2025, lacked documentation of staff intervention or assistance for R1 when he declined to attend a facility outing. The notes did not indicate staff assisted R1 to make or confirm transportation arrangements, or what R1 did or where R1 went when he did not attend a facility outing. During an interview on September 3, 2025, at 11:40 a.m., R1 stated the facility had activities such as going to a movie, out to eat, or to the state fair. R1 stated he did not have to go if he did not want to, but he would have to find somewhere else to go if everyone else went because staff would lock the door of the facility. R1 stated there were a few times last winter he did not want to go on the outing, so he went to a friend's house. R1 stated there was another time in the spring when it was colder out, he and another resident both had to wait outside on the porch for about an hour until staff returned to the facility. During an interview on September 10, 2025, at 12:03 p.m., manager (M)-B stated she asked the residents what they wanted to do and then coordinated with the staff working to do an outing. M-B stated all residents are invited to outings and all residents go to the outings. M-B	0 490		

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0 490	Continued From page 8 stated it is a resident's right to not go on an outing if they do not want to. M-B stated if a resident does not want to go on an outing, staff might reschedule it. M-B stated there have been times R1 did not want to go to an outing, and R1 planned for a person to pick him up every time. M-B stated staff call the resident when they return to the facility, so R1 would know when they were back. During an interview on September 12, 2025, at 3:00 p.m., licensed assisted living director (LALD)-D stated all residents are invited to activities, and outings are done weekly, depending on what the resident's wanted to do. LALD-D stated they try to see on the staff schedule who is available to take the residents out, and who can stay back with any of them who don't go on the outing. LALD-D stated she did not recall any time R1 did not want to go on an outing. During an interview on September 15, 2025, at 11:00 a.m., a community support staff (CSS)-E stated R1 told him he felt pressured to attend the facility outings, and the outings were not blind friendly. The licensee-provided policy titled Resident and Facility Outside Activities dated September 17, 2025, lacked directive on staff procedure related to when a resident declined to attend an outing. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOAH ASSISTING LIVING INC	5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430

(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
02360	Continued From page 9 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 residents reviewed (R1) 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	No plan of correction is required for this tag.	