

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL358676643M  
**Compliance #:** HL358679888C

**Date Concluded:** March 12, 2025

## **Name, Address, and County of Licensee**

### **Investigated:**

Noah Assisted Living  
5100 Xerxes Avenue North  
Minneapolis, MN 55430  
Hennepin County

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

**Evaluator's Name:** Peggy Boeck, RN,  
Special Investigator

**Finding:** Substantiated, individual 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 Alleged Perpetrator (AP) abused a resident when the AP responded to a resident's verbal aggression by fighting with the resident. The AP punched the resident and hit him in the head with an object, which caused injury to the resident in the form of cuts and bruising.

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP received education and training on abuse prevention, the assisted living bill of rights, behavioral health, client boundaries, communication, and conflict resolution. The AP got into the resident's face to confront him about a peer argument, the resident punched the AP, who punched back and struck the resident with an object, causing injury.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The

investigation included review of the resident record(s), facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed the facility, location of the altercation, and staff/resident interactions.

The resident lived in an assisted living facility. The resident's diagnoses included schizoaffective disorder, type two diabetes, and anxiety disorder. The resident's service plan included assistance with medication management, meals, and behavior management. The resident's individual abuse prevention plan provided interventions related to agitation, self-isolation, anxiety, depression, and paranoia. The resident's behavior plan noted the resident had a history of verbal and physical aggression. The plan provided multiple staff interventions, including watching for triggers, speaking softly, staying calm, positioning self to avoid direct confrontation, acknowledging feelings, politely setting limits, and offering choices.

The resident's progress notes indicated a staff was helping a peer with his phone. The peer told the resident staff was helping him, despite advice to avoid interacting with the resident due to previous conflicts. The resident became upset and shouted at the peer using aggressive, threatening language. The note indicated the staff calmly asked the resident to go to his room on the lower level, which he did, and the incident was over.

An incident report indicated the peer then called the AP to come to the facility to talk with the resident about the earlier argument. The report indicated the AP went to talk with the resident and the conversation escalated. The AP and the resident shouted at each other, the resident punched the AP and the AP, "retaliated by fighting with the resident."

During an interview, the staff who witnessed the incident stated the resident had a verbal disagreement with a peer, the staff told the resident to go to the lower level, which the resident did. The staff stated the peer called the AP, who came to the facility. The staff stated she had solved the issue and did not need the AP to get involved, but the AP went downstairs and confronted the resident. The staff stated she heard loud arguing and went to the lower level. The staff stated she saw the resident and AP fighting, punching each other, and the AP hit the resident in the head with the television remote. The staff stated she yelled at both the resident and the AP to stop, which they did. The staff stated she called the police, and the AP went to the hospital, but the resident refused even though he was bleeding. (The resident received a cut on the left side of his head, bruising with swelling on the left side of his head and an abrasion on his forehead.)

During an interview, the nurse stated the AP was not a scheduled employee but picked up shifts when the facility was short staffed. The nurse described the AP as a family member of the owner. The nurse stated the AP "was not at the house anymore". The nurse stated the AP was no longer, "associated" with the facility but remained as part owner. The nurse stated the AP helped the facility in other ways, but no longer worked directly with residents. When asked if

the nurse was aware of any of the resident's behaviors before admission, the nurse stated, "his diagnosis tells you what he is."

During an interview, the resident stated he got in a verbal disagreement with a peer and the peer called the AP. The resident stated he was still angry and did not want to talk about the incident. The resident stated the peer remained upstairs and he stayed in the lower level where his room was. The resident stated the AP came down to talk to him and the resident told him he was not ready to talk. The resident stated the AP got in his face, told him to "be a man", and would not leave him alone. The resident stated he punched the AP first, who then hit the resident in the head with an object. The resident stated they wrestled around on the floor and exchanged more punches. The resident indicated the police came, saw the bleeding cut on his head and asked if he wanted to go to the hospital, which the resident declined.

Video provided by the facility showed the resident with blood dripping down his face, he punched the AP twice, and then backed away.

In conclusion, the Minnesota Department of Health determined abuse 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.

**Abuse: Minnesota Statutes section 626.5572, subdivision 2.**

"Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224.

(2) the use of drugs to injure or facilitate crime as defined in section 609.235.

(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and

(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult.

**Vulnerable Adult interviewed:** Yes

**Family/Responsible Party interviewed:** Yes

**Alleged Perpetrator interviewed:** No, the AP declined to interview.

**Action taken by facility:**

The facility nurse stated the AP was no longer associated with the facility but remained as part owner of the facility. The AP's personnel file indicated the facility "discharged" the AP from employment for physical abuse and fighting.

**Action taken by the Minnesota Department of Health:**

The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

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  
Board of Executives for Long-Term Services and Supports

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>35867</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/27/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NOAH ASSISTING LIVING INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430</b>
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(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order is issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL358679888C/#HL358676643M</p> <p>On February 27, 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 5 residents receiving services under the provider's Assisted Living license.</p> <p>The following correction order is issued for #HL358679888C/#HL358676643M, tag identification 2360.</p>	0 000		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p>	02360		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Minnesota Department of Health

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02360	<p>Continued From page 1</p> <p>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.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility.</p> <p>Please refer to the public maltreatment report for details.</p>	02360		