



# STATE LICENSING COMPLIANCE REPORT

**Report #:** HL358849467C

**Date Concluded:**

**Comfort Care Assisted Living**  
**414 E. 26<sup>th</sup> Street**  
**Minneapolis, MN 55404**  
**Hennepin County**

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

**Evaluator's Name:** Michele Larson, RN

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>35884</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COMFORT CARE ASSISTED LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>414 EAST 26TH STREET MINNEAPOLIS, MN 55404</b>
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0 000	<p><b>Initial Comments</b></p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are 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><b>INITIAL COMMENTS:</b></p> <p><b>#HL358849467C</b></p> <p>On July 28, 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 was one resident receiving services under the provider's Assisted Living license.</p> <p>The following correction orders are issued for #HL358849467C, tag identification 330 and 1130.</p>	0 000	<p>Assisted Living Provider 144G.</p> <p>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.</p> <p><b>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.</b></p> <p><b>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</b></p> <p><b>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.</b></p>	

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

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0 330 SS=D	<p><b>144G.30 Subd. 4 Information provided by facility</b></p> <p>(a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities.</p> <p>(b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide accurate and truthful information to the Minnesota Department of Health (MDH). The licensee provided inconsistent information to MDH regarding the improper discharge of one of one resident (R1) with records reviewed.</p> <p>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).</p> <p>The findings include:</p> <p>R1's medical record was reviewed. R1 was admitted to the licensee's facility on October 31, 2023. R1's diagnoses included but were not limited to insulin-dependent Type 1 diabetes,</p>	0 330		

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0 330	<p>Continued From page 2</p> <p>schizoaffective disorder, intellectual disability, and Post-traumatic stress disorder (PTSD).</p> <p>R1's service plan dated October 31, 2023, indicated R1 received daily assistance with personal cares. In addition, R1 received assistance with safety checks, medication set-up, and managing behaviors three times per day, along with medication administration twelve times per day, and blood glucose readings seven times per day.</p> <p>R1's record indicated on April 15, 2025, the licensee issued a 30-day written notice to terminate R1's housing and services at the facility, citing serious safety concerns. The notice indicated R1 was required to vacate the facility by May 15, 2025. Facility staff would assist in coordinating R1's transition. R1's record indicated R1 continued to receive services and live in the licensee's facility from May 15, 2025 until July 7, 2025. R1's record lacked evidence a new 30-day written notice was provided to R1 and R1's representatives after May 15, 2025.</p> <p>R1's progress note dated May 9, 2025, at 12:13 p.m., documented by LALD-A, indicated during an onsite meeting, LALD-A informed R1 and her mental health case manager (MHCM)-E that two assisted living facilities, Merry Lake and Alliance were willing to accommodate R1.</p> <p>R1's assessment dated May 31, 2025, indicated R1 received scheduled insulin for her uncontrolled Type 1 diabetes. R1 had a history of malnutrition and vomiting. R1 was at risk for self-neglect due to memory issues and mental health diagnoses. R1 was non-compliant with taking medications and insulin as prescribed. Staff were to assist R1 with medication</p>	0 330		

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0 330	<p>Continued From page 3</p> <p>management. R1 required 1:1 staff supervision due to her verbally aggressive behavior.</p> <p>R1's progress note dated July 6, 2025, at 7:14 p.m., indicated R1 voluntarily chose to leave the licensee's facility. According to R1's progress note, R1 contacted Community Outreach for Psychiatric Emergencies (COPE). R1 informed COPE and facility staff she intended to leave for the night and stay with unknown family members.</p> <p>R1's progress note dated July 7, 2025, at 1:01 a.m., indicated the licensee "decided" to discharge R1 after R1 broke a bathroom window and became aggressive with staff. Staff documented it was R1's final warning indicating "and today we decided to discharge her." R1's progress note failed to identify the name of a facility R1 was safely discharged to. R1's record lacked evidence it was R1's informed choice to leave the facility.</p> <p>R1's discharge summary dated July 7, 2025, page 1, indicated on July 7, 2025, R1 was discharged to South Gate Apartments, however, page 2 under discharge information, indicated R1 had no forwarding address.</p> <p>In an email dated July 10, 2025, at 10:03 a.m., from owner (OW)-B to MHCM-E, OW-B indicated R1 was discharged to an assisted living facility of her choice but did not disclose the name of R1's new assisted living facility. OW-B indicated all R1's personal belongings and medications were packed and handed to R1's family members along with R1's discharge summary. OW-B indicated R1's discharge was "long overdue."</p> <p>In an email dated July 10, 2025, at 10:21 a.m., from owner (OW)-B and MHCM-E, OW-B</p>	0 330		

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0 330	<p>Continued From page 4</p> <p>indicated R1 was no longer interested in living at the facility. OW-B indicated CM-C found R1 an apartment indicating R1 was comfortable with her new living arrangements.</p> <p>In an email dated July 10, 2025, at 5:20 p.m., from MHCM-E to OW-B, MHCM-E indicated R1 called her stating the facility kicked her out.</p> <p>In an email dated July 11, 2025, at 8:38 a.m., from OW-B to MHCM-E, OW-B indicated R1's family only took "some of her meds but not all."</p> <p>On July 28, 2025, at 2:24 p.m., owner (OW)-B indicated he was completely unaware of R1's discharge at the time it happened, stating it was the facility's house manager who "discharged" R1.</p> <p>On July 29, 2025, at 11:30 a.m., R1's case manager (CM)-C stated R1 went to a homeless shelter after she was kicked out of the facility, floating between a family member's apartment and the homeless shelter for several days. CM-C stated she picked up R1's belongings from the facility after the facility called stating R1 kept showing up at the facility to retrieve personal belongings left behind. CM-C stated, "They were aware R1 had nowhere to go."</p> <p>On July 31, 2025, at 11:48 a.m., housing support services HSS-D stated R1 moved into Southgate Apartments on July 18, 2025. HSS-D stated on July 21, 2025, he notified the facility R1 moved into the Southgate Apartments after the facility called him stating R1 broke a window while trying to get her belongings.</p> <p>In an email dated August 7, 2025, at 4:14 p.m., from MHCM-E to MDH investigator, MHCM-E</p>	0 330		

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0 330	<p>Continued From page 5</p> <p>indicated during the facility meeting on May 9, 2025, the facility never mentioned any assisted living facilities that would accept R1.</p> <p>In an email dated August 12, 2025, at 2:52 p.m., LALD-A indicated OW-B delivered all of R1's medications to her new residence on an undisclosed date.</p> <p>The licensee policy titled Discharge and Transfer of Residents dated July 24, 2023, indicated residents discharged or transferred from the licensee's facility would have a coordinated process for discharge or transition to another provider or setting.</p> <p>TIME PERIOD TO CORRECT: Twenty-one (21) days.</p>	0 330		
01130 SS=G	<p><b>144G.55 Subd. 2 Safe location</b></p> <p>A safe location is not a private home where the occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel. A facility may not terminate a resident's housing or services if the resident will, as the result of the termination, become homeless, as that term is defined in section 116L.361, subdivision 5, or if an adequate and safe discharge location or adequate and needed service provider has not been identified. This subdivision does not preclude a resident from declining to move to the location the facility identifies.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a safe discharge location or adequate and needed service provider</p>	01130		

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01130	<p>Continued From page 6</p> <p>was identified for one former resident (R1) with record reviewed.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at an isolated scope (when one or a limited number of residents were affected or one or a limited number of staff were involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>Minnesota (MN) Statute 144G.55, Subd. 2, Safe Location. A safe location is not a private home where the occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel. A facility may not terminate a resident's housing or services if the resident will, as a result of the termination, become homeless, as that term is defined in section 116L.361, Subd. 5, or if an adequate and unsafe discharge location or adequate and needed service provider has not been identified.</p> <p>R1's record was reviewed. R1 was admitted to the licensee's facility on October 31, 2023. R1's diagnoses included but were not limited to insulin-dependent Type 1 diabetes, schizoaffective disorder, intellectual disability, and Post-traumatic stress disorder (PTSD).</p> <p>R1's service plan dated October 31, 2023, indicated R1 received daily assistance with personal cares. In addition, R1 received assistance with safety checks, medication set-up, and managing behaviors three times per day, along with medication administration twelve times per day, and blood glucose readings seven times</p>	01130		

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01130	<p>Continued From page 7</p> <p>per day.</p> <p>R1's record indicated on April 15, 2025, the licensee issued a 30-day written notice to terminate R1's housing and services at the facility, citing serious safety concerns. The notice indicated R1 was required to vacate the facility by May 15, 2025. Facility staff would assist in coordinating R1's transition. R1's record indicated R1 continued to receive services and live in the licensee's facility from May 15, 2025 until July 7, 2025. R1's record lacked evidence a new 30-day written notice was provided to R1 and her representatives after May 15, 2025.</p> <p>R1's assessment dated May 31, 2025, indicated R1 received scheduled insulin for her uncontrolled Type 1 diabetes. R1 had a history of malnutrition and vomiting. R1 was at risk for self-neglect due to memory issues and mental health diagnoses. R1 was non-compliant with taking medications and insulin as prescribed. Staff were to assist R1 with medication management. R1 required 1:1 staff supervision due to her verbally aggressive behavior.</p> <p>R1's progress note dated May 9, 2025, at 12:13 p.m., documented by LALD-A, indicated during an onsite meeting, LALD-A informed R1 and her mental health case manager (MHCM)-E that two assisted living facilities, were willing to accommodate R1.</p> <p>R1's progress note dated July 6, 2025, at 7:14 p.m., indicated R1 voluntarily chose to leave the licensee's facility. According to R1's progress note, R1 contacted Community Outreach for Psychiatric Emergencies (COPE). R1 informed COPE and facility staff she intended to leave for the night and stay with unknown family members.</p>	01130		

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01130	<p>Continued From page 8</p> <p>R1's progress note dated July 7, 2025, at 1:01 a.m., indicated the licensee "decided" to discharge R1 after R1 broke a bathroom window and became aggressive with staff. Staff documented it was R1's final warning indicating "and today we decided to discharge her." R1's progress note failed to identify the name of a facility R1 was safely discharged to and lacked evidence it was R1's informed choice to leave the facility.</p> <p>R1's discharge summary dated July 7, 2025, page 1, indicated on July 7, 2025, R1 was discharged to South Gate Apartments, however, page 2 under discharge information, indicated R1 had no forwarding address.</p> <p>In an email dated July 10, 2025, at 10:03 a.m., from owner (OW)-B to MHCM-E, OW-B indicated R1 was discharged to an assisted living facility of her choice but did not disclose the name of R1's new assisted living facility. OW-B indicated all R1's personal belongings and medications were packed and handed to R1's family members along with R1's discharge summary. OW-B indicated R1's discharge was "long overdue."</p> <p>In an email dated July 10, 2025, at 10:21 a.m., from owner (OW)-B and MHCM-E, OW-B indicated R1 was no longer interested in living at the facility. OW-B indicated CM-C found R1 an apartment indicating R1 was comfortable with her new living arrangements.</p> <p>In an email dated July 10, 2025, at 5:20 p.m., from MHCM-E to OW-B, MHCM-E indicated R1 called her stating the facility kicked her out.</p> <p>On July 28, 2025, at 2:24 p.m., owner (OW)-B</p>	01130		

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01130	<p>Continued From page 9</p> <p>indicated he was completely unaware of R1's discharge at the time it happened, stating it was the facility's house manager who "discharged" R1.</p> <p>On July 29, 2025, at 11:30 a.m., R1's case manager (CM)-C stated R1 went to a homeless shelter after she was kicked out of the facility, floating between a family member's apartment and the homeless shelter for several days. CM-C stated she picked up R1's belongings from the facility after the facility called stating R1 kept showing up at the facility to retrieve personal belongings left behind. CM-C stated, "They were aware R1 had nowhere to go."</p> <p>On July 31, 2025, at 8:00 a.m., MHCM-E stated she reached out to the facility after R1 told her the facility kicked her out. MHCM-E stated the facility told her R1 was discharged to a facility of her choice but then told her they spoke to R1 and she was no longer interested in moving into the new assisted living facility. MHCM-E stated on July 10, 2025, R1 told her she was living at a campground but planned on going to the Salvation Army.</p> <p>On July 31, 2025, at 11:48 a.m., housing support services HSS-D stated R1 moved into Southgate Apartments on July 18, 2025. HSS-D stated on July 21, 2025, he notified the facility R1 moved into the Southgate Apartments, stating the facility called him stating R1 broke a window while trying to get her belongings.</p> <p>In an email dated August 7, 2025, at 4:14 p.m., from MHCM-E to MDH investigator, MHCM-E indicated she was never made aware of the two assisted living facilities that were willing to accept R1 into their facilities. MHCM-E indicated she and</p>	01130		

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01130	<p>Continued From page 10</p> <p>R1 had a May 9, 2025, meeting at the facility but indicated the information regarding R1's acceptance to two other assisted living facilities was never discussed.</p> <p>The licensee policy titled Discharge and Transfer of Residents dated July 24, 2023, indicated a safe location was not a private home where the occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel motel.</p> <p>TIME PERIOD TO CORRECT: Two (2) days.</p>	01130		