Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL361579842M
Compliance #: HL361579601C, HL361579191C

Date Concluded: October 1, 2025

Name, Address, and County of Licensee Investigated:

Caring Hearts Home Care
2916 Bloomington Avenue South
Minneapolis, MN 55407
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Maggie Regnier, RN
Special Investigator
Rhylee Gilb, RN
Special Investigator

Finding: Inconclusive

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 he was found unresponsive in his room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident had a history of substance abuse, with a relapse four months prior to admission. Additionally, the resident had chronic unmanaged pain while awaiting a surgery. Although the resident's assessment and service payment indicated staff were to monitor the resident for drug use, the unlicensed personnel (ULP) stated they were unaware of a previous drug history and did not witness the resident use drugs at the facility. The resident was found dead from mixed drug overdose. There was a lack of records for documented services and medication administration. Additionally, the facility provided false information during the investigation, including arranging fraudulent interviews where other individuals misrepresented themselves as facility staff. As a

result, it could not be determined whether neglect occurred or whether any neglect contributed to the death, however, correction orders were issued for related violations.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, autopsy report, death record, staff schedules, staff roster, related facility policy and procedures, text messages and payment checks. Also, the investigator observed staff interactions with other staff, residents and visitors.

The resident resided in an assisted living facility. The resident's diagnoses included history of a seizures, substance abuse, and chronic obstructive pulmonary disease (COPD). The resident's record lacked a service plan and lacked a signed assisted living contract.

The resident's county payment worksheet for services, requested by the facility, indicated the facility would provide 18 hours per day of behavior monitoring, seizure monitoring and one-on-one socialization. The facility also provided assistance with medication administration, medication reminders and weekly medication set-up. The facility indicated they would teach and encourage the resident to stay away from mood altering substances to always maintain sobriety. The facility indicated "If the staff notice any unusual signs such as withdrawal, loss of self-control, stumbling, unsteady gait, flushing of the face, self-isolation, blood shot eyes, loud speech than usual, slurred speech, dilated pupils, rapid eye movements, damp or clammy skin, mood swings, personality changes, agitation, restlessness, irritability, confusion, loss of control and drowsiness. The staff will call the RN and report unusual signs and symptoms and behaviors. The staff will call 911 in case of a medical emergency or the mental health crisis line."

The resident's admission assessment indicated he was independent with activities of daily living but needed help managing his medications. The resident had a history of substance abuse and mental health behaviors. The assessment indicated the resident's mental health was stable. The assessment indicated the resident had right shoulder pain and was awaiting a rotator cuff replacement and chronic low back pain for 7 out of 10 pain rating.

The resident's 14-day assessment indicated the resident took as needed medication for pain. The resident had safety checks every two hours for safety monitoring and indicated staff would monitor for unusual behaviors.

The resident's care plan indicated he received medication reminders and directed staff to monitor for unusual behaviors, aggressiveness, self-isolation, intoxication and substance abuse. However, the care plan did not include the symptoms of substance abuse listed on the county worksheet for staff to monitor and identify. Staff members signed they read the resident's care plan.

The resident's medication orders included a scheduled muscle relaxant three times daily for pain and as needed ibuprofen and acetaminophen. The facility lacked medication

administration records for the medications the resident received. There was no documentation the resident received as needed medications. Only twice daily medication reminders were recorded, although the resident received his muscle relaxant three times daily.

The resident's progress notes indicated over several weeks the resident continued to express shoulder pain and that he could not wait to have surgery for pain relief. The resident record lacked communication with the resident's physician to either get a scheduled date for the surgery nor finding alternative medications or interventions to better manage the resident's pain. The last progress note prior to the resident's death, 11 days prior, indicated the resident rated his pain 8 out of 10 and the pain made it hard for him sleep. The RN encouraged the resident to continue taking his medications for pain.

The resident's record lacked documentation of progress notes by ULP who cared for the resident daily, lacked documented behavior monitoring, and lacked documentation of the every two hour safety checks.

The resident's progress note the day of his death indicated a facility owner, who worked as an ULP, spoke to the resident around 8:00 a.m. for a medication reminder, but the resident wanted to sleep longer. Owner 2 returned to the resident's room to get him for lunch. Owner 2 found the resident unresponsive and called 911.

The resident's autopsy report indicated the resident was found face up on his bed with apparent drug paraphernalia. The resident's death record indicated he died from mixed drug toxicity of cocaine, cyclobenzaprine (muscle relaxant), fentanyl, gabapentin (nerve pain medication) and hydroxyzine (anti-histamine used for anxiety).

The resident's medication orders included scheduled cyclobenzaprine and hydroxyzine, however he was not prescribed gabapentin.

During an interview, a nurse stated the resident was independent and often left the facility during the day to visit friends. The nurse stated the resident had a history of drug abuse, seizures, and shoulder pain. The nurse stated the resident managed his own medications, but the resident did not store his medications; staff would store the medications and give the resident the medications. The nurse stated the resident used Tylenol for his pain, it was helpful, but not as good as it could be because his pain was chronic. The nurse stated the resident planned to get a surgery.

During an onsite investigation, owner 1 emailed a copy of the staffing roster with hand-written staff phone numbers to the investigator. Owner 1 signed the email with her initials. The investigator attempted to contact owner 2 with the number provided on the staffing roster, however he did not return the calls. The investigator called ULP 1 using the number provided on the staffing roster and the person who answered completed an interview with the investigator.

Approximately, one month after the interview with ULP 1, the investigator received information a different individual impersonated ULP 1 and the interview was not with ULP 1. The anonymous report alleged owner 1 provided false phone numbers for her spouse, owner 2 (who found the resident deceased), and ULP 1, (who worked the night shift prior to the resident's death). The report indicated owner 1 paid $1000 to another person to impersonate owner 2 and threatened another person to participate in the impersonation of ULP 1.

A review of the background study data base indicated the phone numbers provided by owner 1 on her staffing roster did not match the phone numbers listed for owner 2 and ULP 1. Additionally, the phone number owner 1 provided for ULP 1 was identified by law enforcement and the background study data base as belonging to a consultant hired by the facility. The phone number provided for owner 2, was a male that was not owner 2, who refused to provide his name. Owner 1 refused to answer whom the number belonged to.

A text message exchanged showed the sender contacted the incorrect phone number provided for owner 2. The text exchanged indicated the sender wrote "Sent you the $1000." The phone number replied, "Thanks I got it." The sender then sent a photo of owner 2's driver's license the day after the investigator was onsite.

When the investigator contacted ULP 1 with the phone number from the background study data base, ULP 1 agreed to an in-person interview with an interpreter service. During the interview, ULP 1 stated she had not been previously interviewed in the case, and it was not her during the previous phone interview. ULP 1 stated she was not aware she was impersonated by someone else. ULP 1 stated she had never met the consultant hired by the facility. ULP 1 stated she did not provide medication services to the resident on her night shift. ULP 1 stated the night before the resident died, he verbally told her he was OK through his door, during her last check at the end of her shift.

When the investigator contacted owner 2 with the phone number from the background study data base, he answered and agreed to an in-person interview. During the interview, owner 2 stated he worked as an ULP at the facility and was out of the country when the resident first admitted. Owner 2 denied seeing the resident use drugs or have related behaviors. Owner 2 stated the account of the day the resident died as the progress note indicated.

Facility check records indicated the consultant was paid around the time of the facility's last survey and received another check for double the amount six days after the resident died.

During a video interview, the consultant stated she had been working with owner 1 on and off over the past year or two helping with facility compliance and policies. When the resident died, the consultant stated owner 1 called her and needed help with the investigation. After the investigator went onsite, owner 1 told her she was not comfortable having her own staff, an employee and spouse, interview with the investigator. Owner 1 had promised to pay the consultant for consulting fees and owner 1 threatened to not pay the consultant and

threatened to have the consultant's employer fire her, and so the consultant impersonated ULP 1 when the investigator called her phone number. The consultant also stated staff did not provide services to the resident as required and did not complete safety checks. Staff were often watching television or on their phones.

During an in-person interview, owner 1 stated she takes applications for admission and the RN completed the admission. Owner 1 stated she spoke with the resident's case manager about services and stated the resident had no prior drug use. Owner 1 stated she hired the consultant after a survey and she was helping with the investigation. Owner 1 stated the consultant provided the staffing list via email to the investigator (although it was provided prior to the investigator leaving onsite when owner 1 was onsite and her initials were on the email signature). Owner 1 stated the staff complained the consultant was telling staff what to do and so owner 1 fired the consultant. Owner 1 stated when MDH began interviewing staff she knew there was a mistake coming from her office by looking through the facility emails but would not elaborate on what mistake she identified.

During an interview, the resident's case manager stated the resident had a history of chemical substance abuse, with a relapse in the summer, prior to his December admission to the facility. The resident was hospitalized inpatient psychiatry after his relapse, was briefly placed in a facility but discharged for using marijuana. The resident was in-between places and homeless prior to placement at the facility. The case manager stated she had an appointment with the facility manager to go over the resident's health history when the resident admitted to the facility, but the manager never came to the house. The case manager stated the licensee submitted the customized living worksheet requesting services for activities of daily living, such as dressing and bathing, but the resident was independent and she had the facility revised their request of services for payment several times. The case manager stated the resident did not like living at the facility and complained staff were not always available to administer his medications because they were stored in a locked cabinet by staff. The resident had plans to move to a new facility, but died prior.

Email correspondences between the resident's case manager and the facility identified owner 1's signature block in the exchange as the person responding.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Deceased.
Family/Responsible Party interviewed: Not applicable, the resident's case manager was interviewed.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility took action immediately when the resident was found unresponsive.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

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 Sheriff
Minnesota Board of Nursing
Minnesota Board of Executives for Long Term Services and Supports
MN Department of Human Services, Program Integrity Oversight

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36157	A. BUILDING: _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HEARTS HOME CARE INC	2916 BLOOMINGTON AVENUE MINNEAPOLIS, MN 55407

(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: HL361579601C/HL361579842M HL361579191C On May 29, 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 4 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for HL361579601C/HL361579842M, HL361579191C, tag identification 250, 450, 1640, 1770, 1820. ******REVISED****** The state form was revised to reflect updated scope and level practice statements for each state correction order cited at the time of the May	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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0 000	Continued From page 1 29, 2025, survey.	0 000		
0 250 SS=I	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or staff of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or staff; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection,	0 250		

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0 250	Continued From page 2 survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee denied access to staff when the licensee provided false phone numbers for staff, participated in a defrauding the agency with a consultant impersonating a staff person and an attempt to have another impersonate an owner of the facility and the licensee owner provided false information during an interview for one of one residents (R1) reviewed. This deficient practice had the potential to affect all residents, staff and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was	0 250		

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0 250	Continued From page 3 issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included post-traumatic stress disorder, schizoaffective disorder and bipolar disorder. R1 failed to have a service plan. R1's care plan dated December 19, 2024, indicated R1 was independent with all activities of daily living. R1 received medication reminders. The care plan directed to monitor for unusual behaviors-aggressiveness, self-isolation, intoxication and substance abuse. R1's assessment dated December 19, 2024, indicated R1 had right shoulder pain, awaiting a rotator cuff replacement and chronic low back pain of 7 out 10 pain rating. R1's assessment indicated he had past history of substance abuse with no current episodes. R1 was homeless prior to admission. R1's customized living worksheet, completed by the facility for requested payment, dated December 25, 2024, indicated a total of 18 hours per day of behavior monitoring services and 1:1 socialization for 2 of those hours. The licensee indicated they would teach and encourage R1 to stay away from mood altering substances to maintain sobriety at all times. The worksheet indicated "If the staff notice any unusual signs such as withdrawal, loss of self-control, stumbling, unsteady gait, flushing of the face, self-isolation, blood shot eyes, loud speech than usual, slurred speech, dilated pupils, rapid eye movements, damp or clammy skin, mood swings, personality changes, agitation, restlessness,	0 250		

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0 250	Continued From page 4 irritability, confusion, loss of control and drowsiness. The staff will call the RN and report unusual signs and symptoms and behaviors. The staff will call 911 in case of a medical emergency or the mental health crisis line." R1's assessment dated December 30, 2024, indicated R1 takes as needed medications for his pain. R1 had safety checks every two hours for safety monitoring. R1 denied seizures and drug use. The assessment indicated staff would monitor for unusual or "highness" behaviors. R1's progress note dated February 21, 2025, indicated unlicensed personnel (ULP), who was an owner (OW)-E spoke with R1 around 8:00 a.m. for medication reminder and R1 wanted to sleep longer. OW-E returned at lunchtime and R1 did not respond through his bedroom door. OW-E unlocked his room and found him on his bed unresponsive. R1's autopsy conducted on February 23, 2025, indicated R1 was found on the day of his death face up, on his bed with apparent drug paraphernalia. R1's death record indicated R1 died on February 21, 2025, cause of death was mix drug toxicity of cocaine, cyclobenzaprine (muscle relaxant), fentanyl, gabapentin (nerve pain medication), and hydroxyzine (anti-histamine use for anxiety). During an interview on June 11, 2025, case manager (CM)-D stated R1 had a history of chemical substance abuse, with a relapse in the summer of 2024. R1 was hospitalized inpatient psychiatry in August 2024, was briefly placed in a facility but discharged for using marijuana. R1 was in-between places and homeless prior to placement at the licensee in December 2024.	0 250		

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0 250	Continued From page 5 CM-D stated she had an appointment with the licensee manager to go over R1's health history when R1 admitted to the facility, but the manger never came to the house. CM-D stated the licensee submitted the customized living worksheet request services for activities of daily living, such as dressing and bathing, but R1 was independent and she had the licensee revised their request of services for payment several times. CM-D stated R1 did not like living at the licensee and complained staff were not always available to administer his medications because they were stored in a locked cabinet by staff. R1 had plans to move to a new facility, but died prior. DEFRAUD OF AGENCY with IMPERSONATION During an onsite visit on May 29, 2025, at 9:30 a.m., the investigator arrived onsite to the licensee. Staff reported owner (OW)-F, who was also the licensed assisted living director, was two hours away. At 11:30 a.m., OW-F arrived and the investigator requested records for the investigation. At 1:00 p.m., no records had been provided to the investigator and OW-F stated she had issues with her printer and was unable to send records via email because she had to print them and scan them to send. An email dated May 29, 2025, at 2:07 p.m., from the licensee to the investigator included the resident roster and staffing roster with staff contact phone numbers. Text message screenshots from an anonymous source indicated the sender contacted the phone number listed on the staffing roster as belonging to OW-E. The text exchange indicated the sender wrote "Sent you the $1000." The phone number replied, "Thanks I got it." The sender sent a photo of OW-E's driver's license on May 30, 2025.	0 250		

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0 250	Continued From page 6 On June 3, 2025 and June 5, 2025, the investigator attempted to contact OW-E using the phone number provided by the licensee, but OW-E failed to return the calls. During an interview on June 3, 2025, the investigator called the number listed on the staff roster for ULP-C to conduct a maltreatment interview. The person participated in the interview impersonating ULP-C. The interview was recorded. On July 8, 2025, an anonymous caller, calling from the phone number listed on the staffing roster as ULP-C called the investigator to inform her the interview conducted on June 3, 2025 with ULP-C was not actually ULP-C but a paid actor to impersonate ULP-C. The anonymous caller stated OW-F pays other people to impersonate her staff when the Minnesota Department of Health (MDH) does investigations. Review of Netstudy indicated the phone numbers listed for ULP-C and OW-E did not match what was provided on the licensee provided staffing roster. The number listed on the staffing roster for ULP-C matched the number in signature emails, White Pages, and NetStudy for consultant (C)-G. Netstudy also indicated C-G was affiliated with OW-F at another facility during the month of May 2025. During an interview on July 10, 2025, the anonymous caller denied being C-G. The anonymous caller stated she participated in impersonating ULP-C on behalf of OW-F. The caller stated the licensee's employees were not	0 250		

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0 250	Continued From page 7 aware they were being impersonated. The caller stated the licensee gets paid for services they do not provide the residents and resident's are paid $20 daily to keep them at the facility, which most will use for drugs. On July 10, 2025, the investigator contacted ULP-C with the phone number listed on Netstudy. ULP-C was not able to speak English and had a friend translate the investigators request for an interview. ULP-C agreed to conduct an in-person interview with an interpreter to be arranged by MDH. During an in-person interview on August 19, 2025, ULP-C, while using an interpreter service, it was not her that the investigator first interviewed on June 3, 2025. ULP-C stated she was unaware someone else conducted an interview with the investigator impersonating her. ULP-C was upset to hear someone was impersonating her. ULP-C stated she had never met C-G. On September 8, 2025, at 2:05 p.m., OW-E was contacted using the phone number listed in NetStudy. OW-E answered and agreed to an in-person interview. OW-E stated he did not need an interpreter service. OW-E participated in the in-person maltreatment interview on September 22, 2025. On September 29, 2025, 12:30 p.m., the investigator called the falsified phone number listed on the licensee staffing roster for OW-E. This was the same number that received a photo of OW-E's driver's license. A man answered, who was not OW-E, and did not speak clear English. The investigator informed the man his phone number was listed as an employee of the licensee. The man stated he knows nothing about	0 250		

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0 250	Continued From page 8 the licensee and refused to share his name. When asked if he knew OW-F, the man hung up the phone call. An email sent on September 29, 2025, at 1:06 p.m., to OW-F and her legal counsel, asked OW-F to identify who's phone number it was that she provided on the staffing roster. OW-F failed to respond and her legal counsel did not answer the question. Instead provided a revised staffing roster. PROVIDED FALSE INFORMATION During an interview on September 22, 2025, at 10:24 a.m, OW-F stated she takes applications for admission and the registered nurse (RN) completes the admission. OW-F stated she spoke with R1's case manager about services and stated R1 had no prior drug use. OW-F stated she hired C-G after a survey and she was helping with the investigation of R1. The day the investigator was onsite, OW-F stated she left at 2:00 p.m. and C-G provided the staffing list via email. OW-F stated when MDH began interviewing staff she knew there was a mistake coming from her office by looking through the licensee emails but would not elaborate on what mistake she identified. A copy of a licensee check dated February 27, 2025, indicated a check was written to C-G in the amount of $4,100 for consulting. During an onsite visit on May 29, 2025, at 11:30 a.m., when OW-F arrived onsite, the investigator provided a list of records needed for the investigation. At 1:00 p.m., no records had been provided to the investigator by OW-F. OW-F stated she had issues with her printer and was unable to send records via email because she	0 250		

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0 250	Continued From page 9 had to print them and scan them to send. An email dated May 29, 2025, at 2:07 p.m., from the licensee to the investigator included the resident roster and staffing roster with staff contact phone numbers. The email signature was signed with OW-F initials. On May 29, 2025, at 2:45 p.m., the investigator left the facility and instructed to OW-F the rest of the documents would need to be provided by email as soon as possible. During an interview on June 11, 2025, CM-D stated R1 had a history of chemical substance abuse, with a relapse in the summer of 2024. R1 was hospitalized inpatient psychiatry in August 2024, was briefly placed in a facility but discharged for using marijuana. R1 was in-between places and homeless prior to placement at the licensee in December 2024. CM-D stated she had an appointment with the licensee manager to go over R1's health history when R1 admitted to the facility, but the manger never came to the house. During an interview on September 8, 2025, at 10:07 a.m., C-G stated she had been working with OW-F on and off for about a year or two helping with compliance and polices. When R1 died, OW-F called her and said she needed help with the investigation. After the investigator went onsite, OW-F told her she was not comfortable having her own staff to interview with the investigator, an employee and her spouse, OW-E who worked the day R1 died. OW-F had promised to pay C-G for consultant work and threatened to not pay her if C-G did not help through the investigation. OW-F also threaten she would go to C-G's employer to have her fired.	0 250		

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0 250	Continued From page 10 C-G stated she paid the person who she intended to impersonate OW-E $1000. C-G stated OW-F gave her ULP-C's employee file and she impersonated ULP-C when the investigator called her. TIME PERIOD OF CORRECTION: Two (2) Days	0 250		
0 450 SS=G	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide person-centered care that complied with the Nurse Practice Act in coordinating heath care services to manage pain for one of one residents (R1) reviewed. R1 had chronic shoulder pain, wanted surgery, however the licensee failed to coordinate getting a surgery scheduled for finding an alternative to manage R1's pain. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 450		

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0 450	Continued From page 11 not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). The findings include: R1's diagnoses included post-traumatic stress disorder, schizoaffective disorder and bipolar disorder. R1 failed to have a service plan. R1's care plan dated December 19, 2024, indicated R1 was independent with all activities of daily living. R1 received medication reminders. R1's facesheet indicated R1 administered on December 19, 2024 and included a list of current medications. R1's assessment dated December 19, 2024, indicated R1 had right shoulder pain, awaiting a rotator cuff replacement and chronic low back pain of 7 out 10 pain rating. R1's progress note dated December 19, 2024, indicated R1 stated his right shoulder bothers him a lot and expected a surgical procedure. R1 knew his medications and wanted to self-administer. R1's customized living worksheet, completed by the facility for requested payment, dated December 25, 2024, indicated, the licensee requested payment for assistance with medication administration with medication reminders, 1.2 hours per day and weekly medication set-up by the nurse. R1's progress note dated December 30, 2024,	0 450		

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0 450	Continued From page 12 indicated R1 rated his shoulder pain 7 out of 10 pain rating. Registered nurse (RN)-A wrote R1 took scheduled and as needed (PRN) medication. R1's progress note dated January 6, 2025, indicated R1 rated his shoulder pain 4 out of 10 pain rating and could not wait for surgery to relieve his pain. RN-A wrote he encouraged R1 to take his medications until the procedure was scheduled and completed. R1's progress note dated January 27, 2025, indicated R1 expressed he could not wait to have surgery for his right shoulder. RN-A wrote R1 denied concerns with his medications. R1's record lacked communication by RN-A to R1's physician for a scheduled date of surgery or coordinating alternative interventions to address R1's pain while awaiting a surgery. R1's physician orders signed February 6, 2025, included scheduled pain medication cyclobenzaprine (muscle relaxant) 5 mg three times daily. PRN pain medication orders included acetaminophen 1000 mg three times per day PRN and ibuprofen 600 mg every six hours PRN. R1's signed physician orders were the same as the medication list on the medication profile and no medication changes were made. R1's progress note dated February 10, 2025, indicated R1 rated his pain 8 out of 10 and the pain makes it hard for him to enjoy his sleep. RN-A documented R1 and his provider were working on getting a surgical intervention completed and R1 had scheduled imaging exams. RN-A encouraged R1 to keep taking his medications for pain.	0 450		

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0 450	Continued From page 13 R1's record lacked communication by RN-A to R1's physician for a scheduled date of surgery or coordinating alternative interventions to address R1's pain while awaiting a surgery. R1's progress note dated February 21, 2025, indicated unlicensed personnel (ULP), who was an owner (OW)-E spoke with R1 around 8:00 a.m. for medication reminder and R1 wanted to sleep longer. OW-E returned at lunchtime and R1 did not respond through his bedroom door. OW-E unlocked his room and found him on his bed unresponsive. R1's autopsy conducted on February 23, 2025, indicated R1 was found on the day of his death face up, on his bed with apparent drug paraphernalia. R1's death record indicated R1 died on February 21, 2025, cause of death was mix drug toxicity of cocaine, cyclobenzaprine (muscle relaxant), fentanyl, gabapentin (nerve pain medication), and hydroxyzine (anti-histamine use for anxiety). During an interview on June 5, 2025, RN-A stated R1 managed his own medications, staff kept them, R1 did not store his medications and staff would give him his medications. R1 had shoulder pain and history of seizures. During an interview on August 26, 2025, at 11:00 a.m., RN-A stated R1 used Tylenol (acetaminophen) for his pain and it was helpful but not as good as could be because his pain was chronic. RN-A stated R1 had been seeing his doctor and planned on getting surgery. RN-A did not recall communicating with R1's case manager.	0 450		

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0 450	Continued From page 14 TIME PERIOD OF CORRECTION: Two (2) Days	0 450		
01640 SS=G	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written service plan, failed to document monitoring services required and identified by the resident's assessment and received payment for services the resident did not require for one of one residents (R1) reviewed. R1 had a history of drug abuse and required 18 hours of supervision and behavior monitoring services. R1 died of drug overdose.	01640		

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01640	Continued From page 15 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). The findings include: R1's diagnoses included post-traumatic stress disorder, schizoaffective disorder and bipolar disorder. R1's unsigned assisted living contract indicated his admission date and effective date of contract were December 19, 2024. R1 failed to have a service plan. R1's assessment dated December 19, 2024, completed by registered nurse (RN)-A, indicated R1 had right shoulder pain, awaiting a rotator cuff replacement and chronic low back pain of 7 out 10 pain rating. R1's assessment indicated he had past history of substance abuse with no current episodes. R1 was homeless prior to admission. R1's assessment indicated R1's preferred bedtime was 11:00 p.m. and wake time between 9:00 a.m. to 11:00 a.m. R1's care plan dated December 19, 2024, indicated R1 was independent with all activities of daily living. R1 received medication reminders. The care plan directed to monitor for unusual behaviors-aggressiveness, self-isolation, intoxication and substance abuse. R1's customized living worksheet, completed by	01640		

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01640	Continued From page 16 the facility for requested payment, dated December 25, 2024, indicated: Behavior Monitoring/Sociaization Services: A total of 18 hours per day of behavior monitoring services, seizure monitoring and 1:1 socialization for 2 of those hours. The licensee indicated they would teach and encourage R1 to stay away from mood altering substances to maintain sobriety at all times. The worksheet indicated "If the staff notice any unusual signs such as withdrawal, loss of self-control, stumbling, unsteady gait, flushing of the face, self-isolation, blood shot eyes, loud speech than usual, slurred speech, dilated pupils, rapid eye movements, damp or clammy skin, mood swings, personality changes, agitation, restlessness, irritability, confusion, loss of control and drowsiness. The staff will call the RN and report unusual signs and symptoms and behaviors. The staff will call 911 in case of a medical emergency or the mental health crisis line." Activites of Daily Living Services: The licensee requested payment for assistance with grooming, 0.5 hours per day; daily cues for grooming, 0.15 hours per day; assistance with bathing, 0.35 hours per day; assist with medication administration with medication reminders, 1.2 hours per day and supportive service to encourage and engage R1 in cleaning, 1 hour per day. Hours of daily direct care services totaled 21.2 hours per day. R1's assessment dated December 30, 2024, indicated R1 was independent with all activities. R1 takes as needed medications for his pain. R1 had safety checks every two hours for safety monitoring. R1 denied seizures and drug use.	01640		

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01640	Continued From page 17 The assessment indicated staff would monitor for unusual or "highness" behaviors. R1's record failed to include a service delivery record for behavior monitoring services (including monitoring for drug use), seizure monitoring services, 1:1 socialization service and cleaning, nor every two hour safety checks identified by R1's assessment. The licensee inaccurately requested payment for services R1 was assessed as independent, including bathing, dressing and grooming. Additionally, the direct care service hours exceeded the amount of sleep time identified in R1's full comprehensive assessment on December 19, 2024. R1's progress note dated February 21, 2025, indicated unlicensed personnel (ULP), who was an owner (OW)-E spoke with R1 around 8:00 a.m. for medication reminder and R1 wanted to sleep longer. OW-E returned at lunchtime and R1 did not respond through his bedroom door. OW-E unlocked his room and found him on his bed unresponsive. R1's autopsy conducted on February 23, 2025, indicated R1 was found on the day of his death face up, on his bed with apparent drug paraphernalia. R1's death record indicated R1 died on February 21, 2025, cause of death was mix drug toxicity of cocaine, cyclobenzaprine (muscle relaxant), fentanyl, gabapentin (nerve pain medication), and hydroxyzine (anti-histamine use for anxiety). During an interview on June 11, 2025, case manager (CM)-D stated R1 had a history of chemical substance abuse, with a relapse in the	01640		

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01640	Continued From page 18 summer of 2024. R1 was hospitalized inpatient psychiatry in August 2024, was briefly placed in a facility but discharged for using marijuana. R1 was in-between places and homeless prior to placement at the licensee in December 2024. CM-D stated the licensee submitted the customized living worksheet request services for activities of daily living, such as dressing and bathing, but R1 was independent and she had the licensee revised their request of services for payment several times. CM-D stated she had scheduled time to meet with the licensee manager at the facility when R1 moved in however the manager never came to the house. During an interview on September 8, 2025, at 10:07 a.m., consultant (C)-G stated she had been working with OW-F on and off for about a year or two helping with compliance and polices. When R1 died, OW-F called her and said she needed help with the investigation. C-G stated staff do not provide the services the licensee was getting paid to provide. C-G stated the staff did not perform safety checks and would often be watching television or on their phones. During an interview on September 22, 2025, at 10:24 a.m, owner (OW)-F, who was also a licensed assisted living director, stated staff complained about C-G telling them what to do and OW-F fired her. An email dated October 1, 2025, at 12:18 a.m., RN-A wrote he completed the customized living worksheet for R1 and obtained information to complete the worksheet through interviews with R1, staff, observation and record review. An email dated September 29, 2025, at 5:46 p.m., from the investigator to OW-F asking to	01640		

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01640	Continued From page 19 provide an explanation of the process on completing customized living worksheets. OW-F failed to respond. TIME PERIOD OF CORRECTION: Two (2) Days	01640		
01770 SS=G	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document medication set-up for one of one residents (R1) reviewed. R1 received scheduled and as needed pain medication for chronic pain. R1 also had a seizure history and received schedule anti-seizure medication. The licensee lacked documentation R1 received his medication. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). The findings include: R1's diagnoses included post-traumatic stress	01770		

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01770	Continued From page 20 disorder, schizoaffective disorder and bipolar disorder. R1 failed to have a service plan. R1's care plan dated December 19, 2024, indicated R1 was independent with all activities of daily living. R1 received medication reminders. The care plan directed to monitor for unusual behaviors-aggressiveness, self-isolation, intoxication and substance abuse. R1's assessment dated December 19, 2024, indicated R1 had right shoulder pain, awaiting a rotator cuff replacement and chronic low back pain of 7 out 10 pain rating. R1's assessment indicated he had past history of substance abuse with no current episodes. R1 was homeless prior to admission. R1's progress note dated December 19, 2024, indicated R1 stated his right shoulder bothers him a lot and expected a surgical procedure. R1 knew his medications and wanted to self-administer. R1's customized living worksheet, completed by the facility for requested payment, dated December 25, 2024, indicated, the licensee requested payment for assistance with medication administration with medication reminders, 1.2 hours per day and weekly medication set-up by the nurse. R1's assessment dated December 30, 2024, indicated R1 takes as needed medications for his pain. R1 had safety checks every two hours for safety monitoring. R1 denied seizures and drug use. The assessment indicated staff would monitor for unusual or "highness" behaviors. R1's progress note dated December 30, 2024, indicated R1 rated his shoulder pain 7 out of 10 pain rating. Registered nurse (RN)-A wrote R1	01770		

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	36157	A. BUILDING: _____ B. WING _____	C 05/29/2025

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01770	Continued From page 21 took scheduled and as needed (PRN) medication. R1's progress note dated January 6, 2025, indicated R1 rated his shoulder pain 4 out of 10 pain rating and could not wait for surgery to relieve his pain. RN-A wrote he encouraged R1 to take his medications until the procedure was scheduled and completed. R1's progress note dated January 27, 2025, indicated R1 expressed he could not wait to have surgery for his right shoulder. RN-A wrote R1 denied concerns with his medications. R1's progress note dated February 10, 2025, indicated R1 rated his pain 8 out of 10 and the pain makes it hard for him to enjoy his sleep. RN-A documented R1 and his provider were working on getting a surgical intervention completed and R1 had scheduled imaging exams. RN-A encouraged R1 to keep taking his medications for pain. R1's progress note dated February 21, 2025, indicated unlicensed personnel (ULP), who was an owner (OW)-E spoke with R1 around 8:00 a.m. for medication reminder and R1 wanted to sleep longer. OW-E returned at lunchtime and R1 did not respond through his bedroom door. OW-E unlocked his room and found him on his bed unresponsive. R1's autopsy conducted on February 23, 2025, indicated R1 was found on the day of his death face up, on his bed with apparent drug paraphernalia. R1's death record indicated R1 died on February 21, 2025, cause of death was mix drug toxicity of cocaine, cyclobenzaprine (muscle relaxant), fentanyl, gabapentin (nerve	01770		

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01770	Continued From page 22 pain medication), and hydroxyzine (anti-histamine use for anxiety). R1's physician orders signed February 6, 2025, included scheduled depakote sodium (anti-seizure) 500 milligrams (mg) four tablets daily at bedtime, sertaline (anti-depressant) 100 mg daily, metoprolol (blood pressure) 25 mg daily, cyclobenzaprine (muscle relaxant) 5 mg three times daily, hydroxyzine 50 mg twice daily. PRN pain medication orders included acetaminophen 1000 mg three times per day PRN and ibuprofen 600 mg every six hours PRN. An email on September 29, 2025, at 5:46 p.m., from the investigator to owner (OW)-F, requested the medication administration records (MAR) for R1 including, medication set-up, medication reminders and PRN medication MARs for December 2024, January 2025, and February 2025. R1's licensee-provided MARs for December 2024, January 2025, and February 2025, only included medication reminder service to take his medications at 8:00 a.m. and 8:00 p.m. R1's record lacked medication set-up MARs to include the medication name, dose and frequency and the date the RN set up the medication. R1's record lacked documentation R1 received any PRN pain medication. R1's record lacked documentation of what medications R1 received with his medication reminders. During an interview on May 29, 2025, unlicensed personnel (ULP)-B stated R1 was independent taking his medications, but he would come downstairs to get the medications.	01770		

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01770	Continued From page 23 During an interview on June 5, 2025, RN-A stated R1 managed his own medications, staff kept them, R1 did not store his medications and staff would give him his medications. R1 had shoulder pain and history of seizures. During an interview on June 11, 2025, case manager (CM)-D stated R1 had a history of chemical substance abuse, with a relapse in the summer of 2024. R1 was hospitalized inpatient psychiatry in August 2024, was briefly placed in a facility but discharged for using marijuana. R1 was in-between places and homeless prior to placement at the licensee in December 2024. CM-D stated R1 did not like living at the licensee and complained staff were not always available to administer his medications because they were stored in a locked cabinet by staff. During an interview on September 22, 2025, at 10:06 a.m., OW-E stated services provided to R1 included medication service. OW-E stated the day R1 died, he worked in the morning and at 8:00 a.m. went to R1's room for his medication, but R1 refused his medication, was tired and wanted to sleep. TIME PERIOD OF CORRECTION: Two (2) Days	01770		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced	01820		

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01820	Continued From page 24 by: Based on interview and record review, the licensee failed to have signed physician orders prior to administering medications for one of one residents (R1) reviewed. 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) 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 diagnoses included post-traumatic stress disorder, schizoaffective disorder and bipolar disorder. R1 failed to have a service plan. R1's care plan dated December 19, 2024, indicated R1 was independent with all activities of daily living. R1 received medication reminders. R1's progress note dated December 19, 2024, indicated R1 stated his right shoulder bothers him a lot and expected a surgical procedure. R1 knew his medications and wanted to self-administer. R1's customized living worksheet, completed by the facility for requested payment, dated December 25, 2024, indicated, the licensee requested payment for assistance with medication administration with medication reminders, 1.2 hours per day and weekly medication set-up by the nurse. R1's facesheet included a list of medications and an admission date of December 19, 2024.	01820		

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01820	Continued From page 25 An email on September 29, 2025, at 5:46 p.m., from the investigator to owner (OW)-F, requested the medication administration records (MAR) for R1 including, medication set-up, medication reminders and PRN medication MARs for December 2024, January 2025, and February 2025. R1's licensee-provided MARs for December 2024, January 2025, and February 2025, only included medication reminder service to take his medications at 8:00 a.m. and 8:00 p.m. R1's record lacked medication set-up MARs to include the medication name, dose and frequency and the date the RN set up the medication. R1's physician orders signed February 6, 2025, included scheduled depakote sodium (anti-seizure) 500 milligrams (mg) four tablets daily at bedtime, prazosin (off-label for PTSD) 2 mg at bedtime, atrovastatin (for cholesterol) 20 mg at bedtime, vitamin D3 5000 unit daily, sertaline (anti-depressant) 100 mg daily, metoprolol (blood pressure) 25 mg daily, cyclobenzaprine (muscle relaxant) 5 mg three times daily, hydroxyzine 50 mg twice daily. PRN medication orders included acetaminophen 1000 mg three times per day PRN, ibuprofen 600 mg every six hours PRN and epinephrine injection 0.3 mg PRN for allergic reaction. During an interview on June 5, 2025, RN-A stated R1 managed his own medications, staff kept them, R1 did not store his medications and staff would give him his medications. R1 had shoulder pain and history of seizures. TIME PERIOD OF CORRECTION: Two (2) Days	01820		