



Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Project: HL362827062M

Date Concluded: June 8, 2026

Compliance Project: HL362826645C

Name, Address, and County of Licensee

Investigated:

Warm Touch Home Care Inc
7548 Fremont Ave South
Brooklyn Park, MN 55444
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lisa Coil, RN, BSN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation: The Minnesota Department of Health (MDH) 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 the resident when the AP pointed a gun at the resident during an altercation.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The owner of the facility contacted the AP to respond to a concern at the facility involving the resident. The AP got into an altercation with the resident and pulled a gun on the resident. During the course of the investigation, it was determined the AP was neither an employee nor a contractor with the facility, therefore, MDH will make no determination on the AP's individual responsibility. However, the facility failed to provide reasonable and necessary care when it reached out to the AP for assistance addressing the resident's behavior.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator contacted the case worker, a family member, and a community member. The investigation included review of the resident record, hospital record, facility incident reports, law enforcement report, related facility policy and procedures.

A concern arose when the resident returned from a hospital and began throwing furniture, such as a television and chairs, off the back deck of the facility building. The resident told the unlicensed caregiver who was present he could do whatever he wanted. Out of concern, the unlicensed caregiver called the housing manager who subsequently contacted the owner. The owner contacted the AP to go to the facility. Soon after arriving, the AP and the resident got into an altercation which led to the AP pulling out a gun on the resident. Law enforcement arrived and both the AP and the resident were taken to the hospital.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder and bipolar disorder. The resident's service plan included assistance with medication management and behavior management. The resident's assessment indicated the resident was orientated.

A facility staff meeting report indicated the owner sought additional assistance from the AP, a volunteer from one of his other businesses, to attempt to intervene. The report indicated The AP displayed what appeared to be a BB gun in a moment of fear which escalated the situation and created additional safety concerns for residents and staff.

Law enforcement records indicated officer(s) were dispatched to the facility for reports of an assault in which turned out to involve the resident and the AP. The report indicated the AP introduced himself as working security and had been contacted by the owner to help with a resident they were having issues with. The report indicated the AP said he and the resident exchanged words; the resident asked the AP what he was doing there, got aggressive, and pushed the AP, injuring the AP's left shoulder. Then the AP pulled a pellet gun out to defend himself against the resident. The AP was requesting an ambulance.

The same law enforcement record indicated the resident told law enforcement when the AP arrived at the facility the resident asked the AP who he was and pushed him away. The resident told law enforcement the AP pulled out a gun and pointed it at the resident.

The same law enforcement report indicated law enforcement performed a brief pat down search of the AP for potential weapons and asked the AP if he had a gun on him. The AP told law enforcement he had put a pellet gun in his vehicle. The law enforcement record indicated the officer went to the AP's vehicle and located a revolver style handgun (BB/pellet gun), loaded with six bullet style cartridges, in a black holster under the driver's seat.

Law enforcement body camera video showed the AP wearing a black stocking hat which said security on it. The law enforcement officer asked the AP if he pulled a BB/pellet gun on the resident and the AP responded with yes, I did because he pushed me. The officer asked the AP if he could look at the gun, to which the AP said the gun was in his car. While the officer and the AP were walking to the car, audio was heard of the officer asking the AP where in the car the gun was, the AP responded by saying it was under the driver's side seat.

The video showed the officer opening the driver's side door, reaching under the seat and pulling out a gun case. The officer then removed a gun from the case, opened the chamber full of bullets, and said it was the "craziest" pellet gun he had ever seen before. The video showed the officer speaking to a medical staff member on scene and told them the gun was not real but sure looked like it. The officer also told the AP it was about as real as it got and asked the AP how it worked. The AP said he had never shot it but went on to explain how it worked.

During an interview, the unlicensed caregiver, who was present that day, stated the resident returned from the hospital agitated. The caregiver stated the resident went to his room, grabbed his television, and threw it off the back deck. The staff member stated she notified the housing manager by phone about the incident, and the housing manager was going to call the crisis team. While waiting for the crisis team to arrive, the caregiver stated "some guy" [the AP] she had never seen before came to the facility. The AP said he was sent there by the owner. The staff member stated the resident came out of his room and asked the AP what he was doing in his house, and the resident pushed the AP. Then the AP pulled something from his waistband. The caregiver stated she heard the resident say shoot me, shoot me, and push the AP down. The AP called 911. The caregiver stated the resident and the AP loudly exchanged words with each other until 911 arrived. Both the resident and the AP were taken to the hospital. The caregiver stated she was not aware of any security guards who worked for the facility.

During an interview, the case worker stated this incident was detrimental to the resident. The worker stated since the incident, the resident was more paranoid with increased frequency of checking to make sure make sure the doors were locked to almost an hourly basis. The case worker stated the resident was more withdrawn since this incident and did not want to visit with her. The case worker stated the resident will only sit down for a five-minute meeting now compared to 30 to 45 minutes prior to this incident.

During an interview, a family member stated the resident lived with paranoia of being kidnapped by armed men. The family member stated prior to the incident, the resident was finally at a point where he could sit in groups and go out in public, but this incident caused a big setback to the residents mental health. The family member stated the resident was terrified, would not leave the house without someone he trusts and is constantly checking to make sure doors are locked. The family member stated this incident was incredibly cruel and terrorized the resident. The family member stated it took the resident almost four months in and out of the hospital with mental health relapses before finally settling into a new facility following the incident; although his mental health is still not back to where it was before this incident.

During an interview, the owner stated he received a call from the housing manager regarding an incident which occurred at the facility. The owner stated the housing manager told him she had called the crisis team. The owner stated sometimes it takes the crisis team a while to get to the facility, so he called a "community member", the AP, to temporarily assist in de-escalating the situation. The owner stated the AP was not an employee nor a contracted staff member for the facility, and the AP was not informed this was an assisted living facility housing vulnerable

adults. In addition, the owner stated he had never had a conversation with the AP prior to this, he had never asked the AP to do this before, and the AP did not work for any type of security company.

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.

“Neglect” means neglect by a caregiver

(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: Yes.

Family/Responsible Party interviewed: Yes.

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

Brooklyn Park City Attorney

Brooklyn Park 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: 36282	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2026
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NAME OF PROVIDER OR SUPPLIER WARM TOUCH HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444
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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 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: #HL362826645C /#HL362827062M.</p> <p>On March 5, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued.</p> <p>The following correction order is issued/orders are issued for #HL362826645C / #HL362827062M. tag identification 2360</p>	0 000	<p>The Minnesota Department of Health documents the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes.</p> <p>The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.</p>	
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 reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>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.</p> <p>Please refer to the public maltreatment report for details.</p>	02360		