Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL363016902M
Compliance #: HL363016362C

Date Concluded: April 8, 2026

Name, Address, and County of Licensee Investigated:
1st Care Inc
8801 10th Avenue South
Bloomington, MN, 55420
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, RN
Special Investigator

Finding: Not Substantiated

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 the resident when the AP threatened the resident for nonpayment of rent. The AP kept the resident's refrigerator and cigarette supply because the resident owed past due rent money. The AP's action caused the resident emotional distress.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The AP and other staff denied staff ever said anything or acted in a way where the resident could have felt fearful, threatened, or scared. The AP denied he kept the resident's refrigerator for nonpayment of rent. Multiple staff reported when the resident moved out, his refrigerator could not fit in the vehicle and left it behind. Staff attempted to contact the resident to pick it up without success. Law enforcement reports did not indicate the resident reported threats or fear of staff. The AP and other staff denied having any of the resident's cigarette supply.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and the AP. The investigation included review of the resident records, facility incident report, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed the facility and staff and the AP's interactions with other residents.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder, bipolar disorder, autism, and anxiety. The resident's service plan included assistance with medication management, and managing the resident's agitation, anxiety, repetitiveness, self-injurious behaviors, and verbal aggression. The resident's assessment indicated the resident was alert, oriented, independent with walking and transferring. The resident was independent with his finance decisions. The resident had paranoia and history of delusions. The resident smoked cigarettes regularly throughout the day. The resident did not smoke in his room and went outside to smoke.

Progress notes indicated the resident went outside and smoked cigarettes daily during his stay at the facility including the day of discharge.

On the day in question, progress notes indicated earlier in the shift the resident became aggressive. ULP (unlicensed personnel) attempted to calm the resident but was unsuccessful. Leadership arrived and attempted to calm and reassure the resident but was unsuccessful. 911 was called. Law enforcement arrived, spoke with the resident, and after a short while, the resident calmed. Behavior records indicated ULP staff provided short simple instructions with partial success. The remainder of the shift, the resident remained composed, cooperative, and stable. During the overnight shift, the resident slept without issues. The next day, in the morning the resident argued with ULP staff. The resident called 911 three times, and they advised calls should only be made in emergencies. Behavior notes indicated throughout the shift staff provided a calm, quiet, and safe environment. Interventions were partially successful. Throughout the remainder of the day, ULP staff validated the resident's expressed feelings, listened to concerns, encouraged breathing exercises, engaged in discussion about underlying behaviors, and offered choices to keep a sense of control. Interventions were successful.

A Law enforcement incident report indicated law enforcement responded to a crisis/mental health call. The call indicated the resident was frustrated, angry, was recording staff and residents, was unable to calm down, and was paranoid. The resident told law enforcement he was upset staff asked about rent. Staff asked the resident not to record in common areas for the privacy of other residents. The resident was cooperative and agreed to have a calm night.

Four days later, progress notes indicated ULP staff reminded the resident it was time for his medications. The resident was visibility upset, demanded to leave, walked quicky, and raised his voice. ULP staff documented they remained calm. The resident called someone to pick him up. Staff reminded the resident of the sign out procedure, but the resident walked out without comment. At 11:00 a.m., the resident returned and staff asked him to take his medications. The

resident refused and went outside. Staff attempted to de-escalate and asked if the resident needed assistance, the resident continued yelling, refused medications, and said “I am recording.” 911 was called. The resident took his medications and vital signs were checked. Throughout the remainder of the shift, staff conducted well-being checks on the resident every two hours.

A law enforcement incident report indicated law enforcement responded to a call for the resident not taking his medication, the resident was frustrated, angry, was not sleeping, and staff wanted the resident taken to the hospital. The resident took his medications after officers spoke with staff. The resident did not meet hold criteria to go to the hospital.

The next morning, progress notes and an incident report indicated the resident smoked in his room around 6:00 am., setting off the smoke alarms, and residents evacuated. The resident was advised and educated on policy and safety. The resident admitted he smoked inside verses in the designated areas. The resident was educated on risks, safety hazards associated with smoking in the facility and advised to smoke only in designated areas. Progress notes indicated after the event; the resident smoked outside in designated areas.

The day after that, progress notes and a discharge summary indicated the resident elected to discharge from the facility due to his dissatisfaction. The resident discharged with his belongings and medications. No concerns were reported or observed at time of his discharge.

A law enforcement incident report indicated the resident moved out of the facility to a new facility. The resident claimed he left behind a refrigerator and a carton of cigarettes. Staff advised the refrigerator was left behind with the resident’s request due to nonpayment and there were no cigarettes left behind.

During an interview, a ULP stated during the resident’s stay, the resident required constant reassurance to let him know he was in a safe place. The day the resident moved ULP said she and others helped the resident pack up his personnel belongings because of the quantity of items to be moved. ULP stated staff assisted packing up the resident’s soft drinks, cigarettes, clothes, freezer food, and these were put into a vehicle the resident was transporting in. ULP stated she did not recall specifically packing up his cigarettes. ULP stated while the resident resided there, the resident never said he ever felt fearful or threatened by anyone at the facility. ULP stated she never seen anyone ever say anything or act in a way where the resident could have felt fearful or scared. ULP stated the facility was a safe place.

During an interview, a nurse stated she saw the resident weekly and at discharge. The nurse said the resident did not say why he was moving out. The nurse said the resident never reported nor had she ever witnessed anyone at the facility ever saying anything or acting in a way where the resident could have felt fearful, scared, or threatened. Upon discharge the resident was at his baseline.

During an interview, leadership stated the resident did not take his small personal refrigerator because it did not fit in the car the resident was transported in to go to the new facility. Leadership stated after discharge, he called the resident multiple times regarding picking up the refrigerator, but the resident did not answer. Leadership said he also told another resident, who the resident still had contact with, to let the resident know he could pick up his refrigerator anytime he would like to. Leadership said during the resident's stay, he spoke to the resident whenever the resident expressed frustration. The resident was frustrated because he felt he did not need to reside at the facility and did not receive enough care. Leadership stated the facility was staffed and staff were available to him. The resident never said he felt threatened, fearful, or scared of anyone at the facility. Leadership also said he did see anyone say anything or act in a way where the resident could have felt fearful or scared.

During an interview, the AP stated he never raised his voice, yelled, screamed, or forced his way into the resident's personal space due to non-payment of rent. The AP said the resident paid rent in cash and the resident had his own funds for soda pop, candy, cigarettes, and shopping. The AP said he did not raise his voice nor act in a way where the resident could have felt threatened or fearful. The AP stated the resident kept his cigarette supply in his room, and at times the resident would lose his cigarettes. Staff would assist in finding them for the resident; at times they would be inside the side of the couch or else ware. The AP denied he kept the resident's cigarette supply and refrigerator for nonpayment of rent. The refrigerator did not fit the vehicle the resident transported in to go to the new facility the resident said he would be back to pick up, however the resident did not return. The refrigerator was available for the resident to pick up at any time. The resident's phone number changed monthly. The AP said the facility did not have any of the resident's cigarette supply. During the resident's stay the resident has admitted, wanted to move, moved/discharged, would request to move back, readmit, on multiple occasions. The AP said why would the resident want to keep coming back if the AP allegedly did these bad things and the resident was not treated well.

The resident did not respond to contact attempts to interview.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means: …
(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;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Vulnerable Adult interviewed: No. Attempted, unable to reach.
Family/Responsible Party interviewed: No. Responsible for self.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility staff provided interventions when the resident had behaviors. The facility staff assisted the resident in discharge to a different facility.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36301	A. BUILDING: _____ B. WING _____	C 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1ST CARE INC	8801 10TH AVENUE SOUTH BLOOMINGTON, MN 55420

(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 On March 5, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL363016362C/#HL363016902M. No correction orders are issued.	0 000		