

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL365615045M
Compliance #: HL365611384C

Date Concluded: October 29, 2025

Name, Address, and County of Licensee

Investigated:

Healing Homes Living Services
83 Cook Avenue West
St. Paul, MN, 55117
Ramsey 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) emotionally abused resident 1 and resident 2 when the AP swung a baseball bat around the facility and caused property destruction. Both resident 1 and resident 2 felt threatened, intimidated, and unsafe. In addition, the AP threatened to remove resident 1's cat from the facility which caused resident 1 emotional distress.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined emotional abuse was not substantiated. Although the AP was upset after resident 2 used racial slurs, placed an overarching tree branch outside over the patio door, and tied a noose around a baseball bat, the AP did not use the bat in a threatening way. In addition, there was no evidence of property destruction. Resident 1's cat was removed from the facility for sanitary concerns.

The investigator conducted interviews with facility staff members, included nursing staff, unlicensed staff, and the AP. The investigator contacted support services personnel, and case

managers. The investigation included review of residents' records, a personnel file, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed staff interactions with resident 1 as well as staff interactions with other residents.

Resident 1 resided in an assisted living facility. The resident's diagnoses included schizophrenia, depression, and anxiety. The resident's service plan included assistance with management of the resident's agitation, repetitive behaviors, elopement threat, resistive tendencies and depression. The resident's assessment indicated the resident walked using a cane requiring occasional supervision on stairs. The resident was disoriented to time requiring reminders.

Resident 2 resided in an assisted living facility. The resident's diagnoses included traumatic brain injury (TBI), bipolar, depression, post-traumatic stress disorder, and anxiety. The resident's service plan included assistance with medication management, management of the resident's agitation, anxiety, hoarding, and resistive tendencies. The resident's assessment indicated the resident walked independently. The resident was oriented to person, place and time.

During an interview, case manager 1 stated resident 2 reported the AP came into the facility with a baseball bat. The AP threatened resident 2 with the bat and destroyed resident 2's personal property. Resident 2 said he felt unsafe to return to the facility and refused to stay there. Case manager 1 stated resident 2 toured a different facility and discharged to different placement. Case manager 1 said resident 2 had increased erratic behaviors and was easily agitated. Case manager 1 stated when he entered the facility the day resident 2 discharged, he did not observe any property destruction.

During an interview, case manager 2 stated resident 2's roommate (resident 1) had similar allegations of the AP threatening the residents with a baseball bat. Case manager 2 stated when she entered the facility, she did not observe any property destruction.

During an interview, the AP stated she was the only person working at the facility one day. Both resident 1 and resident 2 were outside on the patio. The AP went out to the patio. Resident 2 used racial slurs towards the AP which was abnormal for the resident. Resident 2 had also placed an overarching tree branch which hung over the top of the outside patio door. Resident 2 had a baseball bat on the patio which he tied a noose around it. The AP asked if the baseball bat was resident 2's, he said yes, and she took the bat and went inside. The AP said she felt threatened, was trembling, and was scared. The AP said she did hit the bat on the ground and told the residents that this was not OK and said they could not have this type of item on the property. After the incident, both residents went to their rooms which was not abnormal for them to go back to their own personal spaces. Resident 1 told the AP he felt nervous when he heard the banging on the ground of the bat. The AP said she explained to resident 1 that she did not hit the ground with the baseball bat to make him nervous. She said she explained to resident 1 the baseball bat really scared the AP. After the incident, she alerted both resident 1 and 2 when it was mealtime and provided their medications. The AP threw the baseball bat

away. The AP informed resident's 2 case management team of the incident. Prior to the incident, the AP had conversations with resident 2 about past due rent which escalated resident 2's behavior and aggression towards the AP. The AP denied she swung the baseball bat, denied she used the baseball bat to break any household items, and denied that she caused any property destruction. The AP denied kicking in resident 2's room door. The AP denied using the baseball bat to destroy resident 2's personal property in his room. The AP denied swearing at resident 1 or resident 2 and telling them to get off her property or telling them to get out. The AP also denied saying anything or acting in a way that could be perceived by either resident as disrespectful. Regarding resident 1's cat, the AP said the cat's litter box was not getting changed, there was odor, and the cat sprayed urine. The AP said resident 1 was unable to care for the cat. The AP had to remove the cat from the facility for sanitary concerns.

An email record indicated the AP informed resident 2's care team resident 2 had been racially aggressive and had brought in a baseball bat with a noose around it. The AP indicated that resident 2's behaviors had escalated to what felt like physical aggression. Resident 2's behavior began when the AP discussed resident 2's past due rent. The AP had informed resident 2 if they could not reach some level of compliance with his lease agreement that she would exercise her right to work with his case management team to look for different placement as physical aggression towards self or others is a behavior they do not work with at the facility.

During an interview, resident 1 stated the AP had a baseball bat, and said he did not have any concerns with anyone who had a baseball bat. Resident 1 stated he felt safe and had not ever felt fearful or scared of anyone at the facility.

During an interview, unlicensed personnel stated she had seen the AP interact with both resident 1 and resident 2 at the facility. The unlicensed personnel stated she had never witnessed the AP say anything or act in a way where residents could have felt threatened, intimidated, fearful, or scared.

During an interview, a nurse stated there had been no reports from either resident nor from any staff member that resident 1 or resident 2 felt fearful, scared, or felt unsafe. The nurse also said there had been no reports by resident 2 or from staff of resident 2 feeling threatened or intimidated by anyone at the facility. The nurse said he did not observe any property destruction.

During onsite interviews, other residents residing at the facility stated they did not have any concerns with how staff treated them, nor did they have any concerns with staff interactions with them. During observations, there was no evidence of any property destruction.

Another concern identified in the complaint included the AP's failure to provide resident 2 his medications. Resident 2's medication administration record (MAR) indicated occasions resident 2 refused medications. There were also occasions the MAR had incomplete documentation. The facility provided in-service records that indicated on the occasions the MAR was left blank, staff did administer medications, however various staff members failed to document administration.

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: Resident 1 interviewed. Resident 2, attempted but did not reach.

Family/Responsible Party interviewed: No, resident 1 and resident 2 both responsible for self.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility nurse provided staff reeducation and return demonstration of medication administration documentation.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36561	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/14/2025
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NAME OF PROVIDER OR SUPPLIER HEALING HOMES LIVING SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 83 COOK AVENUE WEST SAINT PAUL, MN 55117
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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
0 000	<p>Initial Comments</p> <p>On October 14, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL365611384C/#HL365615045M. No correction orders are issued.</p>	0 000		

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