Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL365699042M
Compliance #: HL365697341C

Date Concluded: June 12, 2025

Name, Address, and County of Licensee Investigated:
Senior Living LLC
7949 Brunswick Avenue North
Brooklyn Park, Minnesota 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, 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) neglected resident 1 and resident 2 when the residents had a verbal altercation which escalated into physical violence. Resident 2 stabbed resident 1 with a knife.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The AP intervened during the verbal altercation between the two residents. It was unforeseen resident 2 had a knife and the AP also intervened as soon as the altercation became physical. The AP removed resident 1 from danger and called 911. The AP also attempted to complete wound care until emergency medical services (EMS) arrived and took over.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and resident 2's social worker. The investigation included review of the resident records, hospital records,

facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed resident 1's hand, staffing, and the layout of the facility itself.

Resident 1 and resident 2 resided in an assisted living facility.

Resident 1's diagnoses included several mental health diagnoses and fetal alcohol syndrome. Resident 1's service plan included assistance with managing behaviors related to mental health concerns. Resident 1's assessment identified him as at risk to abuse other vulnerable adults. The assessment indicated resident 1 had a history of verbal abuse toward other residents and staff when intoxicated. The assessment failed to indicate whether resident 1 was at risk of being abused by others.

Resident 2's diagnoses included several mental health disorders and agitation. Resident 2's service plan included assistance with managing behaviors such as physical aggression. Resident 2's assessment identified resident 2 as at risk to abuse other vulnerable adults. The assessment included interventions for staff to follow to decrease her risk of abusing others including redirection, ensuring the safety of the other residents, not arguing with resident 2 when angry, and calling 911 when the behavior reached a crisis level. The assessment also indicated resident 2 had impaired judgement due to mental health issues.

A facility incident report indicated resident 1 had been in the kitchen, looking for something to eat and making verbal complaints about resident 2. The AP requested resident 1 lower his voice because residents were sleeping, but resident 1 did not listen. Later, resident 2 came out of her room, and the residents began arguing. The AP tried to de-escalate the situation. Resident 2 had been hiding a small knife in her clothes, which she used to stab resident 1 on his hand. Resident 2 also threatened the AP with the knife, but the AP had been able to separate the two residents and called 911. Law enforcement and an ambulance arrived. The ambulance transported resident 1 to the hospital for medical attention. Law enforcement searched the facility for resident 2 and discovered she fled the facility through her bedroom window. Law enforcement later found resident 2 and took her into custody.

Resident 1's hospital record indicated he arrived at the emergency department (ED) with a tourniquet on the left upper extremity and stab wound to the left hand. Resident 1 had surgery on his hand and received stitches. The hospital staff completed a full skin examination and confirmed resident 1 had no other injuries. Resident 1 discharged from the hospital and returned to the facility the same day.

Images taken during the onsite investigation showed resident 1's left hand with scarring going from the palm, around the side, to the back of the hand.

The investigation included review of the law enforcement record, and it was an active investigation.

During an interview, the licensed assisted living director (LALD) stated the two residents normally were very friendly. They knew each other prior to living at the facility, but staff were unsure how long. Issues only occurred with them when they disagreed with each other. The two residents normally did everything together. Regarding the incident, the LALD stated the AP followed policy and procedure and responded immediately. After the incident, the LALD held a staff meeting to discuss what happened and try to figure out what she used as a weapon. All sharp objects were locked in a designated cabinet, so they determined she got it from outside the facility.

During an interview, the AP stated he had been the only staff on duty during the incident. The residents returned to the facility from being out together. They had a disagreement while outside, and the AP instructed them to go to their rooms. Resident 2 went to her room, but resident 1 remained in the kitchen. He spoke loudly about resident 2, and the AP attempted to redirect him several times before he stopped and decided to go to his room. As resident 1 walked to his room, resident 2 suddenly came out of her room and hit resident 1 with a sharp object. As soon as the AP heard the resident scream, the AP went and separated the residents. The AP observed resident 1 had an injury to his hand with bleeding. The AP brought resident 1 to a sink and directed resident 2 to her room. The AP addressed the injury, called 911, and stayed with resident 1 until EMS and law enforcement arrived. After the incident, management held a staff meeting to review the incident and try to figure out how she had a sharp object because the facility locked every sharp object in a cabinet. After resident 1 returned from the hospital, he had a change in attitude but overall seemed to be doing well.

During an interview, resident 1 stated he and resident 2 were outside the facility and had an argument. They returned, and resident 1 tried going to bed. Resident 2 continued to run around the facility, acting aggressive to himself and staff. Resident 1 came out of his room and told resident 2 to stop, since it was about 2:00 a.m. As resident 1 headed to his bedroom, resident 2 opened her door. Resident 1 realized resident 2 attacked him with a knife. Resident 1 had put his hand up, and resident 1 cut him. Resident 1 stated resident 2 did not get the knife from the facility because they locked up all sharp objects. The AP separated the residents, brought resident 1 to the sink to clean the wound, and resident 2 tried to come after resident 1 again. The AP again separated the residents and called 911. Law enforcement arrived, went through the house, and brought resident 1 to the ambulance. Resident 1 went to the hospital and received several stitches. Resident 1 stated the AP protected him.

In conclusion, the Minnesota Department of Health determined neglect 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.

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: Resident 1: Yes. Resident 2: No, attempts to reach for interview not successful.
Family/Responsible Party interviewed: No family involvement for either resident. Both residents were responsible parties for themselves.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Staff were educated on ensuring no sharps are brought into the facility by residents, as well as re-educated on de-escalation strategies.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36569	A. BUILDING: _____ B. WING _____	C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR LIVING LLC	7949 BURNSWICK AVENUE NORTH BROOKLYN PARK, MN 55443

(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: HL365697341C/HL365699042M On April 16, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 3 residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL365697341C/HL365699042M, tag identification 0630.	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.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to identify whether one of two residents (R1) was at risk for being abused. Additionally, the licensee failed to update R1's individualized abuse prevention plan (IAPP) after an incident occurred when R1 was attacked with a knife. 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 fetal alcohol syndrome, depression, and post traumatic stress disorder (PTSD). R1's service plan dated October 23, 2024, indicated R1 received behavior management.	0 630		

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0 630	Continued From page 2 R1's individualized abuse prevention plan (IAPP) dated January 30, 2025, failed to identify R1's risk of being abused by others and therefore specific interventions to keep R1 safe from others. An incident report dated February 2, 2025, indicated around 1:00 a.m., R1 had been in the kitchen, looking for something to eat and talking about another resident (R2). Multiple times, staff requested R1 keep his voice down due to other residents sleeping. R2 approached R1 and they started arguing. Staff tried to de-escalate the two residents. However, unknown to staff, R2 had been hiding a small knife in her clothing. R2 stabbed R1 in his hand. Staff separated the two residents and called 911. R1 went to the hospital and police placed R2 in custody. The licensee failed to update R1's IAPP after the incident occurred. During an interview April 24, 2025, at 4:02 p.m., registered nurse (RN)-B stated the two residents were normally close and were friendly with each other. She stated she did not know if the two residents had previously been physical with each other. RN-B stated the nurse completed the IAPPs. During an interview May 30, 3035, at 11:12 a.m., law enforcement (LE)-F stated in the past, they responded to a report of a different resident throwing a cinder block at R1's ribs. The licensee-provided policy, Individual Abuse Prevention Plan, dated October 1, 2024, indicated the licensee would develop and implement an IAPP for each vulnerable adult. The plan would include the resident's susceptibility to abuse by another individual including other vulnerable	0 630		

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0 630	Continued From page 3 adults. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		