Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL366003542M
Compliance #: HL366006708C

Date Concluded: October 14, 2025

Name, Address, and County of Licensee Investigated:
Suite Living of Brooklyn Park
8500 Regent Avenue North
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Kris Detsch, 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 alleged perpetrator (AP), who was an unknown facility staff member, abused the resident when they restricted his movement by taking away his wheelchair and locking his room. As a result, the resident could not access his bathroom, bedroom, or personal property.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. It could not be determined if staff encouraged the resident to stay out of his room for his safety or if staff consistently locked the resident's door to prevent him from entering due to conflicting information. The resident fell fifteen times within three months while unattended in his room self-transferring. Additionally, the resident was observed sitting in a chair with his wheelchair out of reach, however nursing staff indicated that was not a directive given to the unlicensed personnel (ULP).

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator toured the facility and observed the memory care unit, medication administration, video footage, and documentation systems.

The resident resided in an assisted living facility. The resident's diagnoses included ataxia (impaired balance), dementia, and Parkinson disease. The resident's service plan included assistance with meals, medication administration, toileting, bathing, transfers, and walking. The resident's nursing assessment indicated he moved himself around the unit independently when he was in his wheelchair, but required assistance for transferring. The resident's nursing assessment indicated he was confused, had poor judgement, and required reminders. The nursing assessment indicated he was at risk of falling, and staff members were to encourage him to call them for assistance. Other interventions included staff members were to ensure his environment was free from clutter, all his personal items were within his reach, and to put his bed in the lowest position. The fall interventions lacked indication the staff were to remove his wheelchair, or lock his bedroom door.

Incident reports indicated the resident fell fifteen times within three months. Fourteen of these falls occurred within the resident's room when he was unattended by staff.

While the surveyor toured the memory care unit, the surveyor observed the resident wheeling himself around the unit in his wheelchair. The surveyor observed an unlicensed personnel (ULP) tell him not to enter his room and to remain in the hallway. The resident did not appear distressed, and continued to wheel himself around the unit. The ULP told the surveyor the staff try to keep him out of his room because he falls frequently. A short time later, the surveyor observed the resident sitting in a reclining chair in the lounge area. The resident's wheelchair was in the hallway, apart from him. The same ULP told the surveyor, they keep his wheelchair away from him because he required assistance with transferring, and if left within his reach, he would attempt to self-transfer and fall.

During an interview, a facility nurse said the resident's health declined. The nurse said the resident's ability to walk was poor and he fell frequently. The nurse said the resident had poor insight into his physical abilities. The nurse said they told staff members to keep the resident in the common areas/lounge as much as they could to prevent him from falling, but they did not tell ULP to remove his wheelchair or lock his bedroom door.

During an interview, another nurse said the resident was able to go into his room, however often fell while in there unattended. The nurse said they did not tell the ULP's to lock his room, or remove his wheelchair.

During an interview, a ULP said she observed the resident trying to get into his room, but he could not because staff locked the door. The ULP said she heard the resident holler in an angry

voice for staff to unlock his door. The ULP said the resident was repetitious about this until a staff member arrived approximately five minutes later. The ULP said she asked another ULP why they locked the resident's doors, and the ULP told her it was because the residents were "naughty" (referring to all residents, not just this resident). The ULP said she asked a nurse if this action was on the resident's care plan, but the nurse did not give a definitive answer. The ULP said she continues to observe staff lock the resident's bedroom door. The ULP said she observed staff members place the resident's wheelchair away from him when he sits in the reclining chair in the lobby area, so it is not within his reach.

During multiple investigative interviews, some ULPs acknowledged they moved the resident's wheelchair away from him and/or locked his door for safety reasons because he fell frequently. Other ULP's indicated they did not lock his door, or remove his wheelchair.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(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;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Attempted. Unable to participate.
Family/Responsible Party interviewed: Attempted. Did not respond.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility leadership staff told ULPs to keep the resident's wheelchair next to him.

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
	36600	A. BUILDING: _____ B. WING _____	C 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR CARE OF BP	8500 REGENT 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: HL366006708C/HL366003542M On August 27, 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 29 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL366006708C/HL366003542M, tag identification 450.	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.	
0 450 SS=D	144G.41 Subdivision 1 Minimum requirements	0 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36600	A. BUILDING: _____ B. WING _____	C 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR CARE OF BP	8500 REGENT 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
0 450	Continued From page 1 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, observation, and record review, the facility failed to provide services in a person-centered manner by utilizing confinement as a fall intervention for one of one resident (R1) with record reviewed. The licensee limited R1's access to his room by locking his door and limiting his independent mobility by removing his wheelchair, but they failed to identify when to use these actions, or what interventions staff should complete prior to restricting R1's ability to access his personal space and independent mobility. 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, but was not likely to cause 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).	0 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36600	A. BUILDING: _____ B. WING _____	C 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR CARE OF BP	8500 REGENT 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
0 450	Continued From page 2 The findings include R1 admitted to the licensee for diagnoses including ataxia, dementia, and Parkinson disease. R1's service plan dated December 10, 2024, indicated R1 was "high risk" of falls due to Parkinson disease. The service plan indicated staff would maintain dignity and stability along with ensuring his safety. R1 had safety checks every two hours. R1 required "cue" and assistance with toileting but lacked frequency of the service. R1 had transfers and ambulation assistance for meals, activities, and as needed. The service plan indicated staff would reposition the resident "as needed." R1's service plan report (care plan) dated June 24, 2025, indicated R1 had memory loss and not orientated to person, place, and time. The report indicated staff would monitor and provide safety. R1 was unable to ambulate safely without the use of a "device." Fall interventions indicated as follows: -Staff to keep R1's door open to increase visualization for safety -Safety check at 7:30 a.m. for morning cares to prevent falls -Clutter free; support/assistive devices available and in good repair, the bed in low position at night; personal items and call device pendant, within reach; non-glare soft lighting at night etc. -Required reminders for: call for assistance, use of mobility devices, use of the bathroom, going to activities The fall interventions lacked indication staff were to lock his room, or remove his wheelchair form	0 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36600	A. BUILDING: _____ B. WING _____	C 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR CARE OF BP	8500 REGENT 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
0 450	Continued From page 3 his reach. Incident reports dated April 4, 2025, through June 27, 2025, indicated R1 fell fifteen times. Fourteen falls were inside R1's room, one fall outside of his room. On August 27, 2025, at 8:34 a.m., the surveyor observed R1 wheeling himself around the memory care unit. Unlicensed personnel (ULP)-H told R1 he could not go to his room, and to remain in the hallway. ULP-H told the surveyor staff members try to keep him out of his room because he fell frequently. A short time later the surveyor observed R1 sitting in a reclining chair located in the licensee's lounge area. R1's wheelchair was in the hallway out of his reach. ULP-H said they keep R1's wheelchair away from him because he requires assistance with transferring and if they leave his wheelchair within his reach, he will attempt to "self-transfer" and fall. On August 27, 2025, at 12:17 p.m., regional nurse (RN)-I reviewed video footage with surveyor. Video footage indicated the evening prior, at 3:41 p.m., R1 transferred himself out of the reclining chair (in lounge area) into his wheelchair independently without assist. During review of video footage of August 27, 2025, R1's wheelchair was not within his reach while he sat in the reclining chair. RN-I acknowledged R1 used his wheelchair to assist himself in transferring from the reclining chair into his wheelchair and performed the task independently. RN-I said he should have it next to him. On August 27, 2025, at 2:03 p.m., licensed	0 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36600	A. BUILDING: _____ B. WING _____	C 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR CARE OF BP	8500 REGENT 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
0 450	Continued From page 4 practical nurse (LPN)-A said R1 fell frequently, and staff were to keep him in the common/lounge areas as much as they could to prevent him from falling. LPN-A said nursing staff did not tell ULPs to remove his wheelchair or lock his door. On August 27, 2025, at 1:03 p.m., RN-B said if staff members prevented R1 from going into his room, he would consider that to be a restraint. RN-B said it was safer for R1 to have his wheelchair next to him. RN-B said he did not tell staff to remove R1's wheelchair from him. On September 8, 2025, at 3:08 p.m., ULP-C said she observed R1 sitting in the hallway trying to get into his room, but he could not because of the locked door. ULP-C said staff members continue to lock resident doors, and one ULP told her it was because residents were "naughty." ULP-C said R1's wheelchair continues to be out of his reach. ULP-C said she asked LPN-A if these actions were on R1's care plan, but LPN-A did not give her a definitive answer. On September 9, 2025, at 8:13 p.m., ULP-E said although she did not remember specific information regarding R1, she said it was a "common practice" to lock resident rooms because residents' wander. ULP-E said the staff member who passes medications, has a key to unlock the room. The licensee's policy titled, Bill of Rights, dated July 19, 2025, indicated the licensee would follow the assisted living care bill of rights, including providing person-centered care and services. TIME PERIOD OF CORRECTION: Seven (7) Days	0 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36600	A. BUILDING: _____ B. WING _____	C 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR CARE OF BP	8500 REGENT 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