

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL376397662M  
**Compliance #:** HL376397682C

**Date Concluded:** April 3, 2026

**Name, Address, and County of Licensee**

**Investigated:**

Grace Hand Group Home LLC  
2738 Oakland Avenue South  
Minneapolis, MN 55407  
Hennepin County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Barbara Axness, 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 facility neglected the resident when the facility failed to implement interventions to help reduce the risk of harm related to drug use. The resident overdosed at the facility and was taken to the emergency room for evaluation.

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was not substantiated. The resident experienced at least three overdoses at the facility which required medical treatment. Appropriate interventions were in place to reduce harm to the resident, and facility staff sought immediate medical attention for each overdose. The resident returned to his baseline health condition after each overdose.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case manager. The investigation included review of the resident record, hospital records, facility internal

investigation, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed the resident's room at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included bipolar disorder, substance induced mood disorder, and alcohol use in remission. The resident's service plan included assistance with monitoring behaviors including agitation, self-injurious behaviors, and verbal aggression, five times per day safety checks and medication administration. The resident's assessment indicated the resident had a history of mental illness, substance use and suicidal behaviors. The resident had a history of misuse of methamphetamine, cocaine, and alcohol and had a history of overdose. Interventions included regular mental health and substance use checks throughout the day, and to administer Narcan and call emergency medical services if the resident was found unresponsive. Staff were to provide emotional support and reinforce positive behaviors.

The resident's record indicated the resident was found unconscious in his room during a routine safety check and EMS was called. CPR was performed and the resident was brought to the emergency room and later returned to the facility. About two months later, the resident was found unresponsive in the backyard and EMS was called. The resident was given Narcan and treated in the ER before returning to the facility. The facility made an appointment for the resident with addiction medicine, but the resident refused to attend. Additional interventions were added including educating the resident, increasing safety checks, and monitoring for signs of intoxication. A few weeks later, the resident overdosed again, and EMS was called. The resident was treated in the emergency room and returned to the facility.

During an interview, management stated the resident had difficult behaviors and was in denial over his drug use. The manager stated they were never sure what drugs the resident was on, and he would return to the facility sweating; he'd say he was fine and didn't need help. The manager stated they had tried many interventions with the resident.

During an interview, the facility nurse stated the resident had a lot of mental health and behavior issues. The nurse stated after the resident's first overdose, they implemented new interventions and monitored the resident when he had visitors. The nurse stated the resident refused to see his doctor about his drug use. The nurse stated staff were trained to use Narcan and call 911 if the resident had signs of an overdose.

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:** Yes

**Family/Responsible Party interviewed:** Attempted to contact the resident's case manager

**Alleged Perpetrator interviewed:** Not Applicable

**Action taken by facility:**

The facility implemented interventions and the resident later discharged to another facility.

**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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>37639</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/18/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GRACE HAND GROUP HOME LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2738 OAKLAND AVENUE SOUTH MINNEAPOLIS, MN 55407</b>
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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><b>Initial Comments</b></p> <p>*****ATTENTION***</p> <p><b>ASSISTED LIVING PROVIDER CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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><b>INITIAL COMMENTS:</b> #HL376397662M/ #HL376397682C</p> <p>On February 18, 2026, 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 three residents receiving services under the provider's Assisted Living license.</p> <p>The following correction order is issued for #HL376397662M/ #HL376397682C tag identification 0620.</p>	0 000	<p>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.</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.</p> <p>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.</p>	
0 620 SS=D	<p><b>144G.42 Subd. 6 (a) / 626.557, Subd. 3</b> <b>Compliance with requirements for reporting ma</b></p>	0 620		

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

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0 620	<p>Continued From page 1</p> <p>(a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.</p> <p>The requirement in Minnesota Statute section 626.557, Subd. 3 is:</p> <p>(a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:</p> <p>(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or</p> <p>(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4).</p> <p>(b) A person not required to report under the provisions of this section may voluntarily report as described above.</p> <p>(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.</p> <p>(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.</p>	0 620		
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0 620	<p>Continued From page 2</p> <p>(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) two instances of suspected maltreatment for one of one residents (R1) after he had two overdoses.</p> <p>This practice resulted in a level two violation (a violation that did not harm a client'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).</p> <p>The findings include:</p>	0 620		
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0 620	<p>Continued From page 3</p> <p>R1's diagnoses included bipolar disorder, alcohol use in remission, substance induced mood disorder.</p> <p>R1's assessment dated January 20, 2026, indicated the resident had Narcan to administer as needed. R1 had a history of mental illness and substance use, including methamphetamine and cocaine. R1 had previously been evaluated in the emergency room for substance use and withdrawals.</p> <p>R1's progress notes indicated on August 18, 2025, R1 was found unconscious in his room. Emergency medical services (EMS) was called and CPR was initiated. R1 was treated for an accidental overdose and returned to the facility. The incident was not reported to MAARC.</p> <p>R1's progress notes indicated on October 23, 2025, R1 was found unresponsive in the backyard. EMS was called and R1 was evaluated in the emergency room for an accidental overdose. The incident was not reported to MAARC.</p> <p>On March 11, 2026, at 4:15 p.m., registered nurse (RN)-B stated it would be the facility's process to report any self-neglect to MAARC.</p> <p>The licensee's Vulnerable Adult Maltreatment Prevention &amp; Reporting policy dated July 16, 2021, indicated staff who suspected maltreatment of a resident (abuse, financial exploitation, or neglect), or who had knowledge that a resident has sustained a physical injury which is not reasonably explained would contact the Minnesota Adult Abuse Reporting Center (MAARC). A report would be made no later than 24 hours after the maltreatment was first</p>	0 620		
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0 620	Continued From page 4 suspected.  No further information was provided.  TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		