Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL377133182M
Compliance #: HL377136027C

Date Concluded: September 16, 2025

Name, Address, and County of Licensee Investigated:

Dis-Generation Group Inc
9032 Prestwick Parkway
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lisa Coil, RN, BSN
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 is a nurse at the facility, physically abused the resident when the AP hit the resident in the chest.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was inconclusive. There was no physical evidence the AP hit the resident and there were no witnesses to the alleged incident. Due to conflicting accounts of the incident, it could not be determined whether physical abuse did or did not occur.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record and personnel files. Also, the investigator observed staff interaction with other residents.

The resident resided in an assisted living facility. The resident's diagnoses included post-traumatic stress disorder, traumatic brain injury, major depressive disorder, and anxiety. The resident's service plan included assistance with medication management and safety checks.

The resident's assessment indicated the resident was alert, oriented, verbally abusive, manipulative and exploited others. The assessment further indicated the resident was verbally and physically aggressive, and socially inappropriate.

A concern arose the AP knocked on the resident's door to have the resident fill out some paperwork. The resident said she was too tired to do it, but the AP refused to accept this. The AP knock on the door hard and then broke a different door between the bathroom and resident's room. According to the concern, the AP struck the resident in the chest.

During an interview, the resident stated she was napping in her bed when the AP busted the bedroom door with her hand, broke the lock on a door between the resident's room and the bathroom, started screaming at her, and hit the resident in the chest just because the AP needed the resident to sign some paperwork.

During an interview, the AP stated the resident signed all her paperwork on admit and the only paperwork remaining to be signed was for a family member to sign. The AP denied having an argument regarding paperwork, breaking any doors, or hitting the resident in the chest.

There were no witnesses to the incident, no progress notes or incident reports indicating any type of incident had occurred. There was no report made to law enforcement nor was there any physical evidence identified to corroborate the concern.

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 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; or
(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 unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No, attempted but did not reach.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: No action required.

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
	37713	A. BUILDING: _____ B. WING _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIS-GENERATION GROUP INC	9032 PRESTWICK PARKWAY BROOKLYN CENTER, 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 On June 12, 2025, the Minnesota Department of Health initiated an investigation of complaint HL377136027C/HL377133182M and HL377135009C/HL377132803M. No correction orders are issued.	0 000		