Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL381206542M
Compliance #: HL381205606C

Date Concluded: December 5, 2025

Name, Address, and County of Licensee Investigated:
West Metro Care Services
201 103rd Avenue
Coon Rapids, MN 55448
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Substantiated, facility and individual responsibility

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) abused the resident when the AP physically abused the resident when he punched the resident in the face.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The facility and the AP were responsible for the maltreatment. The law enforcement officer witnessed the AP, who was the owner of the facility, hitting the resident with three hard and fast full punches to the resident's face.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and a family member of the resident. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules,

law enforcement report, related facility policy and procedures. Also, the investigator observed resident care and staff interaction during an onsite visit.

The resident resided in an assisted living facility. The resident's diagnoses included Huntington's disease (a progressive neurodegenerative disorder that causes breakdown of the nerve cells in the brain), bipolar disorder, and glaucoma. The resident's service plan included assistance with eating, drinking, oral hygiene, and body positioning and repositioning. The resident's assessment identified the resident as wheelchair bound and not able to speak.

A law enforcement report indicated a sergeant witnessed the AP assault the resident while responding to a 911 hang up call at the address. The report indicated the sergeant observed through the window the AP punching the resident three times on the left side of her face, and the resident and AP were separated. The report indicated the AP denied he punched the resident and said he wiped the resident's face. The report indicated the resident could not answer law enforcement's questions, and when asked if she was punched, the resident made a sound but in was unclear if that was her way of saying yes. The report indicated the resident buried the left side of her face on her shoulder, and it was unclear if that was a response to pain. The report indicated law enforcement took photographs of both sides of the resident's face and appeared to show redness on the left side of the resident's face. The report indicated the AP was arrested and transported to jail.

The investigator was unable to obtain the photographs taken by law enforcement as the criminal case remained open at the time of the investigation.

A hospital after visit summary indicated the resident was evaluated for assault. The summary indicated no noted facial bone fracture and no acute injury of the neck.

During an interview, the law enforcement sergeant stated a resident at the facility accidently called 911, so he responded. The sergeant stated when he arrived at the facility, he parked on the street and walked toward the side door and knocked. The sergeant stated he saw through the door, through a small kitchen, and saw the resident and the AP sitting at a small dining table. The sergeant stated as he knocked on the door, he saw something upset the AP, and the AP stood up and punched the resident three times in the face. The sergeant stated the AP's arm was fully cocked back and three rapid and aggressive punches landed on the resident. The sergeant stated he entered the facility and yelled to verbally separate the AP from the resident. The sergeant stated he observed spilled milk on the floor, and the AP stated he was wiping the resident's face. The sergeant stated he observed redness on the left side of the resident's face, and no redness on the right side of the resident's face. The sergeant stated he asked the resident if she was punched, and she made a sound, but it was unclear if her answer was yes or no. The sergeant stated he told the AP to call his boss, and when she arrived, the sergeant discovered it was the AP's wife who co-owned the facility with the AP. The sergeant stated the AP again stated he wiped the resident's face. He escorted the AP to his squad car.

During an interview, an unlicensed personnel (ULP) stated he worked with the AP on overnight shifts previously and had no concerns for how the AP treated residents. The ULP stated he has never witnessed staff treat resident's poorly at the facility. The ULP stated he saw the resident the day following the incident and did not observe any signs of injury or pain.

During an interview, a nurse stated she had not heard of or received any prior complaints about the AP. The nurse stated she and the AP were working together on the shift of the incident. The nurse stated she had left the facility and went to the store to get some needed items for the facility, and when leaving, the AP told the nurse he was going to get the resident ready for the day. The nurse stated she had been gone from the facility approximately 30 minutes when she received a phone call from the AP stating she needed to come back due to law enforcement being on site and claiming he assaulted the resident. The nurse stated when she returned to the facility, the AP was in the law enforcement squad car, and she did not get to speak to him. The nurse stated law enforcement told her he witnessed the AP punching the resident. The nurse stated she saw the resident and did not see any signs of being punched in the face, and did not see any signs of pain from the resident. The nurse stated she asked the resident if the AP hit her, and the resident did not respond to her. The nurse stated she called from an ambulance to take the resident to the emergency room (ER) to be evaluated for injury due to the extent of the allegation. The nurse stated there was no injury noted at the hospital, and no injury noted in the following days of observing the resident at the facility. The nurse stated she spoke to the AP later that evening, and the AP denied hitting the resident. The nurse stated the AP stated over and over that he had only wiped the resident's mouth.

During an interview, the AP stated he has worked in healthcare for many years and had always received training on abuse and neglect. The AP stated on the day of the incident; he was covering a shift from 9:00 a.m. to 9:00 p.m. for another staff member. The AP stated he and the nurse worked the shift together. The AP stated when he arrived, all the residents except for one were still asleep. When he later heard the resident's bed alarm sound, he went to her room and proceeded to assist her to get up and ready for the day. The AP stated he then prepared the lunch meal and assisted the resident to eat and drink. The AP stated when the resident was finished, he stood up, wiped her mouth, and started to bring the dirty dishes towards the kitchen when law enforcement entered the facility. The AP stated he was not aware law enforcement was there and was not sure if he had heard law enforcement knocking on the door. The AP stated law enforcement stated the AP had punched the resident in the face. The AP stated he told law enforcement that he had not punched the resident and had only wiped her mouth. The AP stated he repeatedly told law enforcement he did not punch the resident, but law enforcement insisted that he had. The AP denied punching the resident, and stated the only thing he did was wipe the resident's mouth. The AP stated he did not know how law enforcement mistaken wiping the resident's mouth with punching. The AP stated he has not returned to the facility since the incident.

The resident was unable to complete an interview.

During an interview, a family member identified the resident as mostly nonverbal but did understand what was said to her. The family member stated the resident sometimes responded with yes or no, and it was accurate. The family member stated he had no previous concerns about the resident's care and the staff had been pleasant. The family member stated he was notified by law enforcement the resident had been assaulted and struck repeatedly in the face. The family member stated he met the resident at the emergency room, and he did not see any signs of injury to the resident. The family member stated he asked the resident if someone had hit her, and the resident said no. The family member stated he asked the resident again 20 minutes later if someone hit her, and the resident said no. The family member stated the hospital did not find any injury to the resident. The family member stated he was not sure if the AP hit the resident or not, since he was not there.

In conclusion, the Minnesota Department of Health determined abuse was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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;
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

Mitigating factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):
(1) The facility and AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility and AP did not direct an erroneous order, direction, or care plan.

(2) The facility was in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

The AP had the authority to direct and implement operational regulatory requirements or make operational changes.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a foreseen event.

Vulnerable Adult interviewed: No, resident is nonverbal.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The AP's has not worked any shifts since the incident.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Anoka County Attorney
Coon Rapids City Attorney
Coon Rapids Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38120	A. BUILDING: _____ B. WING _____	C 11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST METRO CARE SERVICES LLC	201 103RD AVENUE NORTHWEST COON RAPIDS, MN 55448

(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: HL381205606C/HL381206542M On November 17, 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 four residents receiving services under the provider's Assisted Living license. The following correction order is issuedfor HL381205606C/HL381206542M, tag identification 2360.	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and individual person were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		