Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL408036142M
Compliance #: HL408034462C

Date Concluded: January 20, 2026

Name, Address, and County of Licensee Investigated:
Comfort Care Group
7524 West 101st Street
Bloomington, Minnesota 55438
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 facility abused the resident when the facility unreasonably confined the resident by utilizing a door lock which required a key to exit the building.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the facility previously had a lock on the front door which required a key to be able to leave, the facility removed it. The resident denied feeling like he was being confined and unable to leave the facility when as desired.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed the facility's doors and locks.

The resident resided in an assisted living facility. The resident's diagnoses included several mental health diagnoses. The resident's care plan included assistance with activities of daily living. The resident's assessment indicated the resident needed help to walk and evacuate the facility. The assessment identified him as being at risk for elopement.

During the facility's provisional licensing survey, the engineer observed the front door of the facility which had a double cylinder deadbolt lock. The lock required a key to unlock the door from the inside. The facility received several citations related to this issue.

Five months later, during the investigator's onsite visit, the investigator observed the front door which had a standard deadbolt above the doorknob. Neither of these were turned around so they had to be unlocked with a key from the inside to exit the facility. The investigator also observed a sliding glass door on the same level which the resident resided. The sliding glass door included a security bar which could be pulled out, so the sliding door could be opened. The sliding door created a second exit out of the facility for the resident as needed or desired.

During an interview, the owner, who was also a caregiver, stated the locking mechanism had been like that when he bought the house. The owner stated he thought it was normal, and they always kept the key in the house. As soon as the surveyors came and made him aware, he immediately replaced the lock to ensure compliance. The owner stated he never intended to restrict resident movement or compromise resident safety. The owner stated he took resident safety and compliance very seriously.

During an interview, the resident denied feeling like he was confined or restrained and unable to leave the facility as desired. The resident stated he had a key to the lock.

In conclusion, the Minnesota Department of Health determined abuse 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.

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; 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.
(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: Yes.
Family/Responsible Party interviewed: Not applicable. No family was identified.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility removed the lock from the front door and replaced it with a standard deadbolt.

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
	40803	A. BUILDING: _____ B. WING _____	C 01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE GROUP LLC	7524 WEST 101ST STREET BLOOMINGTON, MN 55438

(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 January 5, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL408034462C/HL408036142M. No correction orders are issued.	0 000		