Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL408039022M
Compliance #: HL408037301C

Date Concluded: April 18, 2025

Name, Address, and County of Licensee Investigated:
Comfort Care Group LLC
7524 West 101st Street
Bloomington MN, 55438
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, 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 they failed to provide supervision when the resident smoked while he wore his oxygen and cut himself with broken glass.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Staff members were with the resident at the time of the incident and acted in his best interest. The resident was angry due to alcohol seeking behaviors and cut himself when he was denied alcohol. The resident did not have a history of self-inflicted injurious behavior and was unforeseen. The staff sent to the resident to the hospital after he cut himself for treatment and medication management which stabilized his mental health and substance abuse. He no longer smoked at the time of the investigation.

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 internal investigation, personnel files, staff schedules, and related facility policy and procedures Also, the investigator toured the facility and observed the designated smoking area, smoke detectors, fire extinguishers, and medication administration.

The resident resided in an assisted living facility. The resident's diagnoses included alcohol abuse, depression, and mood disorder. The resident's service plan included assistance with dressing, grooming, medications, and behavior management. The resident's nursing assessment indicated he walked independently. His memory was intact, but he had a history of hallucinations (false perception) and delusions (false belief) with aggressive behaviors. The resident abused alcohol.

The resident's care plan prior to the incident indicated he smoked five to 10 cigarettes per day and the facility encouraged him to quit. The care plan indicated he was safe to smoke independently.

The resident's individual abuse prevention plan (IAPP) indicated he required assistance with his oxygen. The IAPP indicated the resident had continued problems with alcohol and put himself in vulnerable situations to obtain alcohol. The resident did not have a history of self-injurious behavior or suicide attempts.

Two weeks before the incident, the resident went to the emergency room (ER) for alcohol intoxication. The resident had a referral to the addiction clinic. Six days later, the resident went again to the ER for altered mental status and lab work was completed. The ER referred again to the addiction clinic.

One week prior to the incident, the resident was seen by a provider for psychiatric evaluation with a follow up appointment scheduled and no medication changes.

The day of the incident, the resident had alcohol seeking behavior, broke glass, cut his arm and went to the hospital for treatment. The resident also attempted to smoke while wearing his oxygen. The physician visit indicated he had an ER visit and no hospital stay.

After the incident, the resident's record indicated he continued to with his psychiatric visits and had subsequent medication changes.

During an interview, a manager said the resident was at the facility with a staff member and wanted the staff member to take him to get alcohol. The staff member could not leave the facility unattended, and called him (the manger) who then went to the facility. The manger said he was at the facility with the resident and the resident wanted him to call emergency services (911) to get him alcohol. The manger said he made the resident a cup of coffee, but the resident broke the cup then cut his arm with the glass. The manger said he called 911 after the resident cut himself. The resident went to the hospital and returned to the facility. The manger said he scheduled medical appointments for the resident including appointments with mental health

physicians. The physicians made changes to the resident's medications, and he no longer drinks alcohol or smokes cigarettes.

During an interview, an unlicensed personnel (ULP) said the facility did not allow the resident to smoke with his oxygen on. The ULP said the resident tried to smoke with his oxygen, but they stopped him. The ULP said the resident no longer smoked cigarettes.

During an interview, the resident said he no longer drinks alcohol or smokes cigarettes. The resident showed the surveyor "scars" on his forearm, but said, "It's nothing." The resident said the facility took good care of him.

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: Not Applicable.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility coordinated medical care with multiple medical providers.

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
	40803	A. BUILDING: _____ B. WING _____	C 04/10/2025

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 ******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: HL408037301C/HL408039022M On April 10, 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 two residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL408037301C/HL408039022M, tag identification 630.	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.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update an individual abuse prevention plan (IAPP) after a resident cut himself with broken glass due to alcohol seeking behaviors for one of one resident (R1) with record reviewed. 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 client'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). The findings include: R1 admitted to licensee for diagnoses including alcohol abuse, depression, and schizoaffective disorder. R1's service plan dated December 25, 2024, indicated R1 required assistance with	0 630		

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0 630	Continued From page 2 medications and mental health management. R1's care plan dated January 7, 2025, indicated R1 smoked five to ten cigarettes daily. The care plan indicated the licensee encouraged R1 to quit, but does not plan to quit. The care plan indicated R1 was safe to smoke independently. R1's IAPP dated January 7, 2025, indicated he required assistance with oxygen. The IAPP indicated R1 had continued problems with alcohol and put himself in vulnerable situations to obtain alcohol. The IAPP indicated the licensee would provide a safe environment for him. On January 25, 2025, at 9:30 p.m., R1 had alcohol seeking behaviors, became angry and broke a glass. R1 cut his arm with the broken glass and went to the hospital for treatment. R1 also attempted to smoke while wearing his oxygen. R1's physician visit record dated January 25, 2025, indicated he was evaluated in the hospital emergency room because of agitation, skin abrasions, and self-injurious behavior. R1's IAPP dated March 11, 2025, failed to identify R1's history of physical self-harm and interventions to reduce risks of physical harm. The IAPP failed to contain updated, person-centered, individualized interventions after R1 went to the hospital and interventions to keep R1 safe while smoking with oxygen. The IAPP interventions were unchanged from January 7, 2025. R1's medical record lacked further IAPP assessments.	0 630		

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0 630	Continued From page 3 On April 10, 2025, at 10:20 a.m., R1 said he no longer smoked or consumed alcohol. On April 16, 2025, at 9:55 a.m., registered nurse (RN)-C said she was not working for the licensee at the time of the incident and when she completed nursing assessments and IAPP on March 11, 2025, she was unaware of the incident. RN-C said R1 attends psychiatry appointments, and medical appointments monthly. RN-C said R1 had multiple medication changes which have been helpful in managing his behavior. RN-C said R1 does not smoke cigarettes, or consume alcohol. RN-C acknowledged the IAPP should be updated to reflect these items. RN-C acknowledged nursing assessments, care plans, and IAPP should be updated with accurate information. The licensee's policy titled, Individual Abuse Prevention Plan (IAPP), no date, indicated the licensee would develop and implement an IAPP for each vulnerable adult and which would contain an individualized review or assessment of the persons vulnerabilities. Time period for correction: Fourteen (14) days	0 630		