DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL416046482M
Compliance #: HL416045174C

Date Concluded: June 1, 2026

Name, Address, and County of Licensee Investigated:
Brightview AL Inc
1012 28th Street West
Minneapolis, MN, 55408
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, RN
Special Investigator

Finding: Substantiated, facility 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 facility neglected the resident when they failed to provide supervision. As a result, the resident sustained a burn while cooking.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. While there were conflicting accounts on how the resident's cooking oil burn occurred, the facility knew the resident cooked her own meals and failed to assess the resident for cooking safety. The resident sustained a second-degree burn, was hospitalized, and received treatment in the burn unit. In addition, the facility continued its practice of a resident cooking their own meals without assessing cooking safety.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital records, facility incident reports, and related facility policy and procedures. Also, the

investigator observed the facility and conducted onsite interviews related to the facility's resident meal practices.

The resident resided in an assisted living facility. The resident's diagnoses included cluster B personality disorder, and self-harm. The resident's service plan included meal assistance three times daily. The resident's admission assessment indicated the resident was oriented to person, place, time. The resident's risk of susceptibility of self-abuse was not assessed. The resident walked with a cane, required assistance with shopping as she was unable to carry bags and walk.

The resident's assessment history report indicated an admission assessment and a fall risk assessment at 14-days were completed by nurse #1. No other assessments were completed

The resident's admission assessment was altered and indicated information about a cooking burn incident that occurred a month after admission. At the end of the assessment, the area of the electronic nurse signature was blank and was electronically dated the same day as the investigation onsite visit.

The resident's record did not include an assessment of whether the resident was able to cook safely.

The resident's progress notes indicated 11 days after admission, the resident prepared her own breakfast for herself and her roommate (another resident). The resident said she felt dizzy, and unlicensed personnel (ULP) told the resident to rest. The resident declined and continued to cook. The ULP had to "catch" the resident when she was making her own meals. The resident had an elevated blood pressure of 200/108 (normal is 120/80). After four hours, the resident's blood pressure came back down to 134/73.

The next day, an incident report indicated resident fell asleep while she was cooking. The resident nodded off over the stove and caught a paper towel on fire. ULP #3 intervened and put the paper towel into a sink of water before the fire spread throughout the kitchen. ULP #3 told the resident not to be over the stove, intoxicated, and sleep deprived.

Three days later, the facility nurse completed a fall risk assessment. The assessment lacked any safety interventions. The facility failed to assess the resident's high blood pressure and her health status with intoxication and sleep. The facility also failed to assess the resident's ability to cook safely independently.

After the incident, progress notes indicated the resident continued to prepare food. The resident cooked all night from 3:00 to 5:00 a.m. The resident was not attentive, lost her balance while using grease and was informed she could not leave the stove on without anything cooking. The resident cooked for the other resident who lived there and cooked six meals a day. ULP #3 (not a licensed nurse) told the resident she could prepare meals for herself with

supervision due to her risk of falling. An incident report identified the resident had verbal altercations requiring a mental health crisis team response. The incident report indicated the resident indulged in alcohol and drug use.

The resident’s assessment and care plan did not include an assessment of the resident’s cooking safety. The record indicated the resident “cooked all the time" and she had accidentally set a paper towel she was holding the pan with on fire. The resident also got dizzy but refused to sit or leave the cooking task alone. There were no staff interventions identified. The record indicated the resident was at risk for falls. There were no interventions identified for the resident’s fall risk.

The next week, the resident prepared “excessively” large amounts of food and had flu-like symptoms and continued to prepare food on the stove.

The resident then had a care conference. There was no discussion about the resident's cooking safety. There were issues identified with resident’s drug and alcohol use leading to the transferring of the other resident out of the facility’s care. They discussed concerns with the resident taking drugs outside of the facility's knowledge as well as the resident had controlled substances and had alcohol in her possession. The facility documented they also suspected the resident was using street drugs.

The resident’s record did not include an assessment of the resident’s suspected street drug use, controlled substances in her possession, and/or alcohol use with interventions or direction of what staff were supposed to do to ensure the resident’s safety.

During the next month, progress notes indicated the resident continued to prepare and make her own food. The resident requested ongoing reheating of food she prepared. In the early morning hours, ULP staff documented the resident prepared food in the kitchen numerous times.

The progress notes lacked evidence ULP staff were in the kitchen with the resident, supervised, or assisted the resident with any cooking tasks.

Approximately one month after admission, an incident report indicated the resident came downstairs at 11:00 a.m. and walked into the kitchen. The resident said she had already eaten breakfast, did not need any assistance, and said she was leaving for the day. ULP #1 logged into the computer to do charting. The resident put oil in the pan. The resident “screamed” out saying call 911. ULP #1 went back to the kitchen to see what happened. The resident said she burned her [right] hand. ULP #1 called 911. ULP #1 documented the resident got mad when staff tried to help her in the kitchen.

The resident’s emergency room and hospital records indicated the resident sustained second degree burns to her right arm and hand from hot liquid. The circumstances of the injury

occurred while cooking and the resident spilled grease on her arm. The resident admitted to the burn unit for treatment. The facility reported to the hospital the burn was self-inflicted, but the resident denied purposely burning herself.

Upon discharge from the hospital, progress notes indicated the resident was informed by the facility not to use the kitchen and was to request staff to make her meals according to the week's meal plan, warm up her food, handle hot beverages, pan and oil due to safety concerns. The resident had limited use of her right arm so she would be designated assist of one for activities of daily living.

The resident's service delivery records remained the same before the incident of the resident nodded off at the stove and after the oil burn injury. There was no assistance with activities of daily living (ADL's) identified outside of bathing assistance, which remained the same. The resident had meal assistance and reminders three times daily which also remained the same.

After the oil burn injury, the resident's progress notes indicated ULP staff cooked and prepared meals for the resident, ULP staff made "light preparation meals," and ULP staff informed the resident she was unable to use the kitchen independently.

The resident was discharged from the facility.

During onsite observations, upon entering the front entrance/lobby main level area a staff workstation was located at the bottom of a staircase. The main level area which housed the kitchen was not open concept. Off the staff workstation area was a hallway that led to a U-shaped kitchen. The stove top/range was located off the countertop separated away from the kitchen sink. On the other side of the kitchen was a communal dining and living room space.

Review of the current staff schedule indicated there was one ULP scheduled on the 7:00 a.m. to 3:00 p.m. shift, one ULP on the 3:00 p.m. to 11:00 shift, and one ULP on the 11:00 p.m. to 7:00 a.m. shift.

During onsite compliance interviews, multiple facility staff members stated all three current residents residing at the facility preferred to fix and cook their own meals. The current resident roster indicated all three residents received meals at the facility. Nurse #2 said she did not assess nor observe a current resident's cooking practices. Nurse #2 stated she did not know this resident cooked his own meals. ULP #1 said this resident made his own breakfast, bacon and eggs.

During an interview, the resident stated the day of the oil burn she was transferring grease from the pan into a teapot container to put grease into. Her left arm went numb, and she spilled the grease onto her lower right arm and right hand. The resident stated staff were not watching her cook. The resident said at times staff were not around, would be outside, or came in at odd times. The resident stated she cooked at the facility often and wanted to cook her own food.

The resident stated the facility blamed her for the oil burn. The resident stated the facility staff did not have conversation with her about supervising her cooking. The resident did not recall a paper towel starting on fire. The resident said she moved out of the facility.

During an interview, a family member stated the resident had been cooking meals on her own and was under the impression the resident would be getting meals prepared for her or help in the kitchen. The resident lost hold of the cooking instrument she was using which caused an oil burn. The resident had a weak wrist and strength in her primary right hand. The family member stated a staff member could have assisted lifting a pot with oil in it for someone who had a weak wrist like the resident and who was also dealing with active health issues.

During an interview, ULP #1 stated the day of the oil burn, the resident came downstairs, was dressed and was prepared to go out for the day. The resident told ULP #1 to go upstairs “right now” to clean the resident’s room and to tend to her laundry. ULP #1 stated she went upstairs. While ULP #1 was upstairs, the resident went into the kitchen and burnt her hand with oil. ULP #1 said there was nothing out in the kitchen that was being prepared to cook. ULP #1 stated staff made sure they were around and watched when residents cut veggies or used the stove.

During an interview, ULP #2 stated they were supposed to be with the resident in the kitchen when the resident cooked. The resident did not like that and would “scream” at staff to get away. At times when the resident cooked, the resident would request staff to get things from her room and/or get items for her from the second floor. Staff would leave the area, and the resident would be alone in the kitchen space.

During an interview, ULP #3 stated one day she was washing dishes in the kitchen sink, and the resident was at the stove top cooking. Paper towels were next to the stove. The resident set a paper towel on fire. ULP #3 stated she grabbed the lit paper and put it out in the sink. The resident cooked meals large enough for a household of people. The resident cooked a lot of meat, made pork chops, vegetables, and potatoes. The resident would leave food out because she did not eat much of what she cooked. The resident needed reminders food needed refrigeration. The resident got angry when her leftover food containers were thrown out. The resident would ask staff for reheating of the food she prepared.

During an interview, nurse #1 stated when she conducted the resident’s admission assessment, the resident did not have any limitations with use of her hands. The resident refused the facility’s cooked food; however, the resident was able bodied, able to cook under their management, and there were staff available to aid the resident when she cooked. The resident cooked daily. After the oil burn incident, the resident was told not to cook in the kitchen. Nurse #1 said she watched video footage of the incident. The resident was seen cooking oil and poured it on herself over the sink. Nurse #1 stated during the resident’s stay, she did not conduct a specific assessment of the resident’s ability to cook safely nor observe the resident cooking. Nurse #1 stated the resident required assistance of one staff with her activities of daily living (ADL's) due to fall precautions and said this would be identified in her record. Nurse #1

stated she did not know if the resident was specifically identified as requiring assistance of one staff with cooking. Nurse #1 stated ULP #3 reported the resident started a paper towel on fire, at the time the resident was non-coherent. Nurse #1 said she was not made aware of it, it was reported and said she was unsure of when she learned of the incident.

During an interview, leadership stated the facility cannot refuse to allow residents to cook who want to. There were residents who do not like to be managed or looked over. If the resident refused services of staff cooking, residents had that right to refuse. Leadership said they do not try to push them over the edge and help them when they can. The resident cooked her own food and wanted to cook for herself. Leadership stated most of the residents do not like being supervised or watched. The resident told ULP #1 to go fix up her room as the resident was leaving for the day. The resident went straight to the kitchen. Leadership stated he watched video footage of the resident's oil burn incident. He stated he saw the resident put oil in a pan on the stove top then spilt the oil over her arm. In the meantime, the resident was seen on video looking back and forth to see if staff were coming.

Video footage was requested but not received.

In conclusion, the Minnesota Department of Health determined neglect 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.

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: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility staff contacted emergency medical services (EMS) after the burn occurred, and the resident transferred to the hospital. After the resident returned from hospitalization, the facility restricted the resident's use of the kitchen.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

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
Hennepin County Attorney
Minneapolis City Attorney
Minneapolis Police Department
Minnesota Board of Executives for Long Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41604	A. BUILDING: ______ B. WING ______	C 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW AL INC	1012 28TH ST W MINNEAPOLIS, MN 55408

(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: HL416045174C/HL416046482M On May 5, 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 3 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for HL416045174C/HL41604682M, tag identification 0330, 1620, 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.	
0 330 SS=I	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide	0 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41604	A. BUILDING: ______ B. WING ______	C 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW AL INC	1012 28TH ST W MINNEAPOLIS, MN 55408

(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
0 330	Continued From page 1	0 330		

accurate and truthful information to the department during a survey, investigation, or other licensing activities.
(b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to provide accurate and truthful information to the Minnesota Department of Health (MDH) by providing an altered nursing assessment for one of one resident (R1) reviewed. This had the potential to affect all residents.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

R1 admitted to the licensee on August 16, 2025. R1's diagnoses included Cluster B personality disorder, and self- harm.

R1's Admission Assessment dated August 17, 2025, indicated R1 needed assistance getting in and out of shower, and getting dressed. R1 could not safely use appliances. R1 stated her hand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41604	A. BUILDING: ______ B. WING ______	C 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW AL INC	1012 28TH ST W MINNEAPOLIS, MN 55408

(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
0 330	Continued From page 2	0 330		

went numb and she had an accident but upon reviewing footage R1 had injured herself. R1 said she sustained a to her right arm burn, 911 was called. After making sure help arrived she was observed actually pouring oil on herself. R1's case manager requested R1 not to use the kitchen and meals should be prepared by her staff. The assessment indicated R1 would need meals cooked and prepared for her.

R1's Admission Assessment dated August 17, 2025, at the bottom of the record where a nurse signature would be identified had a red "X," the signature area left blank, and was electronically dated May 5, 2026, the day of the investigation onsite visit.

R1's Master Care Plan completed August 31, 2025, did not indicate nor identify R1's oil burn incident or cooking interventions.

R1's Individual Abuse Prevention plan completed August 31, 2025, did not indicate nor identify R1's oil burn incident or cooking interventions.

R1's incident report dated September 21, 2025, indicated R1 put oil in a pan, R1 yelled out that said she burned her hand, 911 was called. R1 had an oil burn.

R1's progress notes dated September 21, 2025, indicated R1 was at the emergency room and sustained a 2nd degree burn. The progress notes indicated after reviewing footage, R1 was witnessed boiling oil checking for the staff member if she was nearby, standing over the sink contemplating self-harm.

R1's emergency room and hospital records dated September 21 though 24, 2025, indicated R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41604	A. BUILDING: ____ B. WING ____	C 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW AL INC	1012 28TH ST W MINNEAPOLIS, MN 55408

(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
0 330	Continued From page 3	0 330		

sustained a right arm and hand burn from hot liquid and hospitalized.

R1's progress notes dated September 24, 2025, indicated R1 returned from the hospital. The progress notes indicated R1 was informed per her case manager R1's was not to use the kitchen and R1 was to request staff to make her meals according to the weeks meal plan, warm up her food, handle hot beverages, pan and oil due to safety concerns. R1 had limited use of her right arm so she would be designated assist of one for activities of daily living (ADL).

During an interview on May 12, 2026, at 12:34 p.m., registered nurse (RN)-D stated when she conducted R1's admission assessment, R1 did not have any limitations with use of her hands. R1 was able bodied, able to cook under their management, and there were staff available to aid when she cooked. RN-D stated there were no prior burns with R1's cooking and R1 cooked daily. After the oil burn incident, R1 was told not to cook in the kitchen.

During an interview on May 13, 2026, at 2:30 p.m., owner (OW)-F, who was also the licensed assisted living director, stated he retrieved R1's admission assessment and records from their medical record software. When discussing R1's admission assessment dated August 17, 2025 which identified an oil burn, however records indicated R1's oil burn occurred on September 21, 2025, OW-F stated he did not believe or not to his knowledge did anyone alter R1's admission assessment. OW-F stated the admission assessment that showed an "X" and a date of May 5, 2026, could be when the record printed out. During another interview on May 13, 2026, at 2:58 p.m., OW-F stated if his memory served him

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41604	A. BUILDING: ______ B. WING ______	C 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW AL INC	**1012 28TH ST W MINNEAPOLIS, MN 55408**

(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
0 330	Continued From page 4 correctly when he had spoken to RN-D during the timeframe of R1's admission, R1 had a burn incident before admission to their facility. OW-F stated that could be why the admission assessment reflected an oil burn. TIME PERIOD FOR CORRECTION: Two (2) days	0 330		
01620 SS=J	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41604	A. BUILDING: ______ B. WING ______	C **05/05/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW AL INC	**1012 28TH ST W MINNEAPOLIS, MN 55408**

(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
01620	Continued From page 5 practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) assessed residents cooking practices for safety for two of two residents (R1, R2) reviewed. While cooking, R1 nodded off at the stovetop and set a paper towel on fire. There was no evidence R1's cooking practices was assessed before the incident nor interventions added after the incident for R1's safety. Three weeks later, R1 sustained a second-degree burn from hot liquid (oil) requiring hospitalization. R2 cooked his own meals at the licensee. R2's cooking practices were not assessed for safety. This practice resulted in a level four violation (a violation harmed a resident's health or safety, not	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41604	A. BUILDING: ___ B. WING ___	C 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW AL INC	1012 28TH ST W MINNEAPOLIS, MN 55408

(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
01620	Continued From page 6	01620		

including serious injury or death, or a violation that was likely to lead to serious injury 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
R1 admitted to the licensee on August 16, 2025. R1's diagnoses included cluster B personality disorder, and self-harm.

R1's admission assessment dated August 17, 2025, indicated at the bottom of the record where a nurse signature would be identified had a red "X," the signature area left blank, and was electronically dated May 5, 2026, the day of the investigation onsite visit. Additionally the assessment dated "August 17, 2025," included information about a burn incident that occurred on September 21, 2025. The assessment indicated R1 needed assistance getting in and out of shower, and getting dressed. R1 could not safely use appliances. R1 stated her hand went numb and she had an accident but upon reviewing footage R1 had injured herself. R1 said she sustained a burn to her right arm, 911 was called. After making sure help arrived she was observed actually pouring oil on herself. R1's case manager requested R1 not to use the kitchen and meals should be prepared by her staff. The assessment indicated R1 would need meals cooked and prepared for her.

R1's Assessment History report indicated R1 had an admission assessment dated August 17, 2025, and fall risk assessment conducted August 31, 2025. There were no other assessments

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41604	A. BUILDING: ______ B. WING ______	C 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW AL INC	**1012 28TH ST W MINNEAPOLIS, MN 55408**

(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
01620	Continued From page 7	01620		

conducted.

R1's service recap dated August 2025, indicated R1 received meal assistance and meal reminders three times daily.

R1's progress notes dated August 27, 2025, indicated R1 prepared food during the overnight shift. R1 prepared breakfast for herself and her roommate. R1 said she was dizzy, the unlicensed personnel (ULP) checked blood pressure; it was 200/108. The ULP asked R1 to rest, R1 refused and continued cooking. R1 sung, danced, and chatted with the other resident while cooking. Later that day, progress notes indicated the ULP contacted RN-D and reported R1 felt dizzy and had to catch R1 when R1 was making meals today. RN-D had the ULP recheck blood pressure, R1 refused. After four hours R1 agreed and blood pressure was 130/73, it was checked again after than at 134/73.

R1's progress notes dated August 28, 2025, indicated R1 assisted her roommate with styling of her hair. R1 washed her own hair and completed her grooming tasks in the kitchen sink. The ULP documented they advised her washing her hair in the kitchen sink was not appropriate for personal hygiene and recommended for R1 to use the bathroom sink. R1 declined and completed her personal care routine.

R1's incident report dated August 28, 2025, at 6:00 p.m., which was documented on August 31, 2025, indicated R1 fell asleep while cooking. R1 nodded over the stove and caught a paper towel on fire. ULP-C grabbed a towel and the paper towel and threw them into the sink of water before it spread through the kitchen. R1 claimed she saw the "napkin" on fire and ULP-C did not give

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41604	A. BUILDING: ______ B. WING ______	C 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW AL INC	**1012 28TH ST W MINNEAPOLIS, MN 55408**

(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
01620	Continued From page 8	01620		

her a chance to put the paper towel fire out. ULP-C documented she told R1 she should not be over the stove, intoxicated, and sleep deprived, as it was a fire hazard at this point. Leading up to the incident, R1 had asked for specific food items she liked to eat and cook herself. R1 cooked three to four times daily.

R1's record lacked a nursing assessment after R1 started a fire while cooking to assess R1's safety when cooking.

R1's progress notes dated August 29, 2025, indicated R1 prepared and consumed food during the overnight shift.

R1's progress notes dated August 30, 2025, indicated R1 was seen in the urgent care due to applying Nair (hair removal substance) on her body. R1's did not return with an after-visit summary. R1 stated no medications were prescribed.

R1's record did not indicate the licensee attempted to obtain urgent care records from the visit nor conduct monitoring if R1's reaction from the Nair product resolved.

R1's incident report dated August 30, 2025, indicated R1 was up all-night cooking from 3:00 a.m. to 5:00 a.m. The same report also indicated R1 and her roommate were arguing back and forth.

R1's progress notes dated August 30, 2025, documented by ULP-C indicated R1 was in the kitchen, cooked food, was not attentive to her balance and was using grease. R1 was informed she could not leave the stove on without anything cooking, as this posed a fire hazard. R1 believed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41604	A. BUILDING: ___ B. WING ___	C 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW AL INC	1012 28TH ST W MINNEAPOLIS, MN 55408

(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
01620	Continued From page 9	01620		

she needed six meals a day, including cooking for their new resident who moved in. R1 was informed by ULP-C (not a licensed nurse) that she could prepare meals for herself with supervision due to her risk of falling.

R1's incident report dated August 31, 2025, indicated R1 and another resident who resided at the licensee had a verbal altercation, repeated verbal confrontations, which nearly turned physically aggressive. Staff intervened and the mental health crisis team and police arrived. R1 was provided pamphlets from the mental health crisis team. The incident report indicated that R1 indulged in alcohol and drug use.

R1's Master Care Plan completed August 31, 2025, indicated R1 needed cues to take shower and clean up, did not identify any assistance with dressing needs. The master care plan did not indicate R1 was unsafe to use appliances. The master care plan did not indicate R1 needed meals cooked and prepared for her. The master care plan indicated "R1 cooked all the time" and she had accidentally set a paper towel she was holding the pan with on fire. R1 also got dizzy but refused to sit or leave the task alone. There were no interventions identified. R1's master care plan indicated R1 walked with a cane, required assistance with shopping as she was unable to carry bags and walk.

R1's fall risk assessment completed August 31, 2025, indicated R1 was a fall risk. There were no interventions identified.

R1's Individual Abuse Prevention Plan (IAPP) completed August 31, 2025, indicated R1 cooked all the time, and she accidentally set a paper towel she was holding the pan with on fire. R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41604	A. BUILDING: ______ B. WING ______	C 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW AL INC	**1012 28TH ST W MINNEAPOLIS, MN 55408**

(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
01620	Continued From page 10	01620		

Continued From page 10

also got dizzy but refused to sit or leave the task alone. There were no interventions identified. The IAPP also did not identify R1's altercation with the other resident (roommate) which had mental health crisis team and police involvement. The IAPP lacked assessment if R1 was at risk to be abused, risk to abuse others, or if R1 was at risk to abuse themselves.

R1's service recap dated September 2025, indicated R1 received meal assistance and meal reminders three times daily.

R1's progress notes dated September 3, 2025, indicated R1 prepared "excessively" large food portions.

R1's progress notes dated September 7, 2025, indicated R1 had an "abundance" of food prepared on the stove and offered staff some to eat. Staff opted to decline.

R1's progress notes dated September 8, 2025, indicated R1 had a care conference. There was no documentation of discussion about the resident's cooking safety. The progress notes indicated issues with R1's drug and alcohol use leading to the transferring of another resident out of the licensee's care. They discussed concerns with R1 taking drugs outside of the licensee's knowledge as well as R1 had controlled substances, and had alcohol in her possession. The licensee also suspected R1 was using street drugs. R1's case manager concluded the licensee was not a good match for R1 and would be looking for other placement.

R1's record did not include an assessment of R1's suspected street drug use, controlled substances in her possession, and/or alcohol use

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41604	A. BUILDING: _______ B. WING _______	C 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW AL INC	1012 28TH ST W MINNEAPOLIS, MN 55408

(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
01620	Continued From page 11	01620		

with interventions or direction of what staff were instructed to do to ensure R1's safety.

R1's progress notes dated September 13, 2025, indicated in the early morning hours, R1 was observed waking and independently preparing food for herself in the kitchen.

R1's progress notes dated September 16, 2025, indicated R1 was up in the middle of the night and got her food together.

R1's progress notes dated September 18, 2025, indicated that in the early morning hours R1 entered the kitchen and prepared food for herself, asked staff to reheat the food, and serve it to her upstairs.

R1's progress notes dated September 19, 2025, indicated R1 accessed the kitchen independently in the early hours of the morning and prepared a meal. R1 asked staff to reheat the food and serve it to her in her room.

R1's progress notes dated September 21, 2025, indicated R1 made a "delicious" breakfast at 5:30 a.m. and offered ULP a plate.

R1's incident report dated September 21, 2025, indicated R1 put oil in a pan. R1 yelled out and said she burned her hand, 911 was called. R1 had an oil burn.

R1's progress notes dated September 21, 2025, indicated R1 was at the emergency room and sustained a second degree burn. After reviewing footage, R1 was witnessed boiling oil checking for the staff member if she was nearby standing over the sink contemplating self-harm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41604	A. BUILDING: ______ B. WING ______	C 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW AL INC	1012 28TH ST W MINNEAPOLIS, MN 55408

(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
01620	Continued From page 12	01620		

R1's emergency room and hospital records dated September 21, 2025, indicated R1 sustained second degree burns to her right arm and hand from hot liquid. R1 admitted to the burn unit for treatment. The licensee reported to the hospital R1's burn was self inflicted. R1 denied purposely burning herself.

R1's progress notes dated September 24, 2025, returned from the hospital. The progress notes indicated R1 was informed per her case manager R1's was not to use the kitchen and R1 was to request staff to make her meals according to the weeks meal plan, warm up her food, handle hot beverages, pan and oil due to safety concerns. R1 had limited use of her right arm so she would be designated assist of one for activities of daily living.

R1's record did not include an assessment after hospitalization.

R1's service recap summary for the months of August and September 2025 remained the same. There was no assistance with ADL's identified outside of bathing assistance. R1 had meal assistance and reminders three times daily which also remained the same.

R1's discharge summary indicated R1 discharged from the licensee October 13, 2025.

An email dated May 6, 2026, at 1:19 p.m., from owner (OW)-F indicated R1 refused to provide summaries after visit so formal assessments could not be conducted due to R1's lack of cooperation.

During an interview on May 8, 2026, at 9:59 a.m., R1 stated the day of the oil burn she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41604	A. BUILDING: ______ B. WING ______	C 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW AL INC	1012 28TH ST W MINNEAPOLIS, MN 55408

(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
01620	Continued From page 13	01620		

transferring grease from the pan into a teapot container to put the grease into. Her left arm went numb, and she spilled the grease onto her lower right arm and right hand. R1 stated staff were not watching her cook. R1 stated she cooked at the licensee often and wanted to cook her own food. R1 stated the licensee said she burnt herself which was untrue. R1 stated the licensee staff did not have conversations with her about supervising her cooking.

During an interview on May 11, 2026, at 12:34 p.m., RN-D stated when she conducted R1's admission assessment, R1 did not have any limitations with use of her hands. R1 refused the licesensee's cooked food, however R1 was able bodied, able to cook under their management, and there were staff available to aid R1 when she cooked. RN-D stated there were no prior burns with R1 cooking and R1 cooked daily. After the oil burn incident, R1 was told not to cook in the kitchen. RN-D stated she did not conduct a specific assessment of R1's ability to cook safely nor observe R1's cooking. RN-D stated R1 was an assist of one with her ADL's due to fall precautions and said this would be identified in her record. RN-D stated she did not know if R1 was specifically identified as being an assist of one with cooking prior to the oil burn. RN-D stated she conducted an admission assessment, a 14 day assessment, and stated R1 would not let them assess her after the burn incident. RN-D stated ULP-C reported R1 started a paper towel on fire. This was caused because R1 was non-coherent. RN-D said she was not made aware and was unsure of when she learned of the incident.

The licensee's staff schedule for the month of May 2026, indicated there was one ULP

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41604	A. BUILDING: ______ B. WING ______	C 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW AL INC	**1012 28TH ST W MINNEAPOLIS, MN 55408**

(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
01620	Continued From page 14	01620		

scheduled on the 7:00 a.m. to 3:00 p.m. shift, one ULP on the 3:00 p.m. to 11:00 shift, and one ULP on the 11:00 p.m. to 7:00 a.m. shift.

The licensee's current resident roster indicated R2 received meals. Two other residents listed on the current roster also indicated they received meals.

R2
R2 admitted to the licensee on April 26, 2026. R2's diagnoses included diabetes mellitus type II.

R2's assessment dated April 27, 2026, indicated R2 was oriented to person, place, and time. R2 was independent with eating and drinking. The assessment did not indicate R2 cooked independently, nor did it indicate if R2 cooked safely. The same assessment indicated "Home Care Facility does grocery shopping."

During an observation on May 5, 2026, at 11:08 a.m., upon entering the front entrance/lobby a staff workstation was located on the bottom of the stairs. The lower-level area which housed the kitchen was not open concept. Off the staff workstation was a hallway that led into a U-shaped kitchen. The range was located on a wall. The kitchen sink was located on the back wall, and the dishwasher was located on the wall opposite of the range. On the other side of the kitchen was a communal dining and living room space.

During an observation on May 5, 2026, at 11:08 a.m., a posted white board was in the hallway which indicated a "shift to-do list." 7:00 a.m. to 3 p.m. shift indicated breakfast and lunch. The 3:00 p.m. to 11:00 p.m. shift indicated dinner. During observations, R2 was speaking to both ULP-A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41604	A. BUILDING: ____ B. WING ____	C 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW AL INC	**1012 28TH ST W MINNEAPOLIS, MN 55408**

(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
01620	Continued From page 15 and ULP-C. R2 told ULP-C he did not want to be woken for his 9:00 a.m. medications like he was today. R2 stated to both ULP-A and ULP-C that as independent as he was, if he wanted breakfast, he cooked it himself. During an interview on May 5, 2026, at 11:08 a.m., ULP-A stated staff prepared meals, and said it depended on whether residents cooked their own food or not. During an interview on May 5, 2026, at 11:35 p.m., OW-F, who was also the licensed assisted living director, stated ULP prepared meals, and the residents cooked their own meals. OW-F stated there were three meals a day. During an interview on May 5, 2026, at 11:55 a.m., ULP A and ULP-C both stated residents at the licensee fixed and cooked their own meals. Both ULP's stated the residents do not want meals cooked for them by staff. They stated it was residents' preference to cook their own meals. ULP-A stated at times staff do supervise residents when they cook. ULP-A stated for example a resident who they discharged would intentionally set off fire/smoke alarms, so they had to watch him cook. During an interview on May 5, 2026, at 12:15 p.m., R2 stated he cooked his own food at the licensee. R2 said it was his preference to cook and said he did not want anyone at the licensee cooking for him. During an interview on May 5, 2026, at 12:25 p.m., RN-E stated she had not seen R2 cook his own meals and said R2 had not cooked any meals since he admitted. RN-E called ULP-A over to the area and asked ULP-A if R2 cooked.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41604	A. BUILDING: ______ B. WING ______	C 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW AL INC	**1012 28TH ST W MINNEAPOLIS, MN 55408**

(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
01620	Continued From page 16	01620		

ULP-A stated yes, R2 cooked his own bacon and eggs for breakfast. RN-E further stated she did not observe nor assess R2's ability to cook because she did not know R2 was cooking. RN-E stated if residents at the licensee were cooking, she would need to conduct an assessment and observe R2 to see if he cooked safely.

During an interview on May 12, 2026, at 10:32 a.m., RN-E stated the licensee's assessment process included preadmission, admission, 14-day, every 90 days, and as needed assessments with change of conditions. Change of condition assessments would include after any hospitalization or after incidents.

The licensee's policy titled Vulnerable Adult Policy, dated June 2, 2025, indicated the licensee would assess the resident's vulnerability status upon admission. would develop an individual abuse prevention plan. The plan would contain an individualized review or assessment of the person's susceptibility to abuse by others, risk of abusing other vulnerable adults, and self-abuse. The plan would contain statements of the specific measures to be taken to minimize the risk.

The licensee's policy titled Assessments, Reassessment, dated June 2, 2025, indicated a registered nurse would conduct an initial assessment, reassessment no more than 14 days later, and ongoing reassessments every 90 days or resident monitoring based on changes in needs of the resident.

The Minnesota Nurse Practice Act, MN statute 148.171, subdivision 15, indicated the practice of professional nursing included providing a comprehensive assessment of a resident's health status to establish a plan of care and address

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41604	A. BUILDING: ____ B. WING ____	C **05/05/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW AL INC	**1012 28TH ST W MINNEAPOLIS, MN 55408**

(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
01620	Continued From page 17 changes in condition which included implementing interventions, delegating nursing tasks and evaluating the response to interventions for effectiveness. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, 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 reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		