Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL421222760M
Compliance #: HL421221067C

Date Concluded: May 4, 2026

Name, Address, and County of Licensee Investigated:
Liberty Assisted Living LLC
2519 83rd Court North
Brooklyn Park, MN, 55444
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
Special Investigator
Rhylee Gilb, 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 facility neglected the residents (resident #1, resident #2, resident #3, and resident #4) when they failed to provide supervision. As a result, the residents smoked inside the sunroom and discarded cigarettes onto the wood paneling ledges, and on the carpet.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility and the alleged perpetrator (AP) were responsible for the maltreatment of resident #1, resident #3 and resident #4. The AP, who was the facility owner and the licensed assisted living director (LALD), moved two of the three smoking residents (resident #1 and resident #4) to the facility after their previous facility had a fire, where he was also the LALD. The facility inaccurately assessed the residents' ability to smoke independently and safely for resident #1, resident #3 and resident #4. Resident #2 did not smoke. The facility staff allowed the residents to smoke

cigarettes inside a “sunroom” connected to the dining area of the building. The sunroom contained windows with wood paneling ledges, covered in cigarette butts, soot and ash. Below the ledges, on the carpet were scattered cigarette butts, soot, ash and burn holes. At the time of the onsite investigation, there were unattended smoldering cigarettes on a wooden window ledge. The AP had control to implement and enforce safe smoking practices for fire prevention and failed to supervise that staff and residents were compliant.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a case worker. The investigation included review of the resident records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed smoke detectors, fire extinguishers, facility exits, staffing structure and documentation systems.

The residents resided in a provisional assisted living facility. Resident #1 and resident #4 were the first admissions to the facility. They admitted for emergency relocation as their previous assisted living facility was uninhabitable due to damage from a fire.

Resident #1’s diagnoses included schizoaffective disorder (mood disorder, hallucinations and delusions). His service plan indicated he required behavior management. His behaviors included property destruction, agitation, anxiety, and psychosis (hallucinations/delusions). He required safety checks three times per day. His nursing assessment was from the previous facility and indicated he was safe to smoke independently.

The facility failed to complete an admission assessment, including a smoking assessment when resident #1 admitted to the facility.

Resident #4’s diagnoses included traumatic brain injury, and epilepsy (seizures). His service plan indicated he required behavior management. His behaviors included agitation, anxiety, wandering, and verbal aggression. His nursing assessment was from the previous facility and indicated he was safe to smoke independently.

The facility failed to complete an admission assessment, including a smoking assessment when resident #4 admitted to the facility.

Resident #3’s diagnoses included schizoaffective disorder, post-traumatic stress disorder (PTSD), and substance use disorder. His service plan indicated he required behavior management. His behaviors included property destruction, agitation, anxiety, and psychosis (hallucinations/delusions). He required safety checks three times per day. His nursing assessment inaccurately indicated he did not smoke.

The surveyor toured the facility and observed a sunroom attached to the dining/living room. The sunroom walls had wood paneling and carpet on the floor. The windows had pronounced wood ledges which contained soot, ash, burn areas, and cigarette butts. The carpet below the

ledges also contained soot, ash, burn holes and cigarette butts. There were multiple burn holes the approximate size of a quarter through the sunroom carpet, not limited to below the window ledges. The sunroom had a dining room chair facing the window, but no other furniture. The surveyor did not observe any “no smoking” signs. The sunroom had a foul odor of smoke. Upon leaving the sunroom, the surveyor asked the unlicensed personnel (ULP) if the facility allowed residents to smoke inside the sunroom. The ULP said she was unsure.

A few minutes later, the surveyor brought the facility nurse to the sunroom and showed her these observations. The nurse acknowledged this posed a risk of fire. The nurse showed the surveyor a fire extinguisher they facility kept underneath the kitchen sink. The nurse later declined a further interview.

The surveyor brought the AP to the sunroom. Upon entering, resident #1 and resident #3 were smoking inside the sunroom. The ULP was sitting at the dining room table, next to the sunroom. There were glass doors between the dining room, and sunroom so the sunroom was observable. The surveyor pointed out the smoldering cigarettes unattended on a window ledge to the AP. The AP then told the two residents they needed to smoke outside. The surveyor showed the AP the burn holes throughout the carpet, along with soot and ash. The AP told the ULP to have the residents smoke outside.

During an interview, the AP said the facility trained their staff (ULPs) when they hired them to have the residents smoke outside. The AP said the facility conducted fire drills twice a year and fire extinguishers were accessible. The AP said smoke detectors were present and functioning. The AP said the burn holes (quarter sized) were in the carpet before they moved the residents into the facility. The AP acknowledged there were cigarette butts scattered on the carpet. The AP said the residents could not smoke in the sunroom and should only smoke outside. The AP acknowledged resident #3’s nursing assessment inaccurately indicated he did not smoke.

Property records indicated the AP purchased the home approximately three years prior to receiving a provisional assisted living license. Inspection records for the provisional license application included an environmental checklist. The checklist included a list of items that required repair as they did not meet requirements. Those items did not include existing burn holes in the carpet. There was a follow up inspection completed with the AP onsite when those items were cleared for the provisional license.

The facility failed to provide a policy regarding their rules for smoking.

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: No. Attempted resident #1 and #4. Unable for resident #2 and #3.
Family/Responsible Party interviewed: No. Attempted for resident #2 and # 4. Not Applicable for resident #1 and #3.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility provided re-direction/re-education to staff and residents about smoking outside.

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
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department

Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42122	A. BUILDING: _____ B. WING _____	C 03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY ASSISTED LIVING LLC	2519 83RD CT N BROOKLYN PARK, MN 55444

(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: HL421221067C/HL421222760M On March 31, 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 four residents receiving services under the provider's Provisional Assisted Living license. The following correction orders are issued for HL421221067C/HL421222760M, tag identification 180, 830, 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.	
0 180 SS=F	144G.16 Subd. 2 Initial survey (a) During the provisional license period, the	0 180		

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0 180	Continued From page 1 commissioner shall survey the provisional licensee after the commissioner is notified or has evidence that the provisional licensee is providing assisted living services to at least one resident. (b) Within two days of beginning to provide assisted living services, the provisional licensee must provide notice to the commissioner that it is providing assisted living services by sending an e-mail to the e-mail address provided by the commissioner. (c) If the provisional licensee does not provide services during the provisional license period, the provisional license shall expire at the end of the period and the applicant must reapply. (d) If the provisional licensee notifies the commissioner that the licensee is providing assisted living services within 45 calendar days prior to expiration of the provisional license, the commissioner may extend the provisional license for up to 60 calendar days in order to allow the commissioner to complete the on-site survey required under this section and follow-up survey visits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to notify the Minnesota Department of Health (MDH) within two days of starting services when they moved two of two residents (R1 and R4) to alternate location with a provisional licensure. This move occurred on February 17, 2026, emergently due to a fire. The licensee then admitted two additional residents (R2 and R3) without notifying MDH within two days or starting services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 180		

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0 180	Continued From page 2 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: MDH issued a provisional licensure to the licensee effective September 15, 2025, through September 14, 2026. On February 17, 2026, Capital Home Health Care HFID 34360 residence had a fire which made the structure uninhabitable. Licensed assisted living director (LALD)-A did an emergency evacuation of R1 and R4 to the licensee, where he was also the LALD and the owner. On February 19, 2026, at 10:56 a.m., LALD-A told MDH Capital Home Health Care HFID 34360 moved two residents to alternate location due to a fire which occurred. MDH confirmed the address with LALD-A, however the location address was another Capital Home Health Care facility and no longer licensed by MDH. On March 31, 2026, at 8:32 a.m., the surveyor arrived at the address of the emergency relocation. The building appeared as a "home" setting. There was no response when the surveyor rang the doorbell. On March 31, 2026, at 9:26 a.m., the surveyor called LALD-A. LALD-A gave a the licensee address as the location Capital Home Health Care moved the residents to after the fire occurred. LALD-A said the residents moved to the location on February 17, 2026. LALD-A said he	0 180		

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0 180	Continued From page 3 was unsure if he notified MDH about moving the residents to this location, and said he would have to talk it over with registered nurse (RN)-B. LALD-A said he notified the ombudsman. On March 31, 2026, at 10:24 a.m., the surveyor arrived at the licensee. Unlicensed personnel (ULP)-C was there and identified herself as the only caregiver working at the time. ULP-C said there were four residents residing in the building (R1, R2, R3, and R4). R4's facesheet and records indicated the facility name was Capital Home Health Care (CHHC), with HFID 34360 address. R4 admitted to HFID 34360 on February 7, 2023, for diagnoses including total brain injury (TBI) and epilepsy. R1's facesheet and records indicated the facility name was Capital Home Health, with HFID 34360 address. R1 admitted to HFID 34360 on January 1, 2026, for diagnoses including schizoaffective disorder. Although, R2 and R3 admitted to the licensee after Capital Home Health's fire on February 17, 2026 and there was no habitable house to admit to, their facesheets and records also indicated the facility name was Capital Home Health Care with HFID 34360 address. R2 admitted into the licensee on February 18, 2026, for diagnoses including bipolar disorder. R3 admitted into the licensee on March 3, 2026, for diagnoses including schizoaffective disorder, post-traumatic stress disorder (PTSD), and substance abuse disorder. On March 31, 2026, at 10:33 a.m. RN-B said she	0 180		

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0 180	Continued From page 4 was not sure if the licensee notified MDH regarding moving the residents to the location and told the surveyor to ask LALD-A. RN-B said the surveyor should ask LALD-A any questions regarding licensure. RN-B said R2 was supposed to admit into the other location, but could not admit there because of the fire, so he admitted into the licensee. RN-B said R2 never lived at the prior location, but they scheduled him for admission at the time of the fire, so that's why he admitted into the licensee. RN-B said the licensee moved three residents into this location from the prior location because of the fire and identified the residents as (R1, R2, R4). On April 16, 2026, at 12:03 p.m., LALD-A said all four residents (R1, R2, R3, and R4) were residents at the prior location before moving urgently to the new/current location with the provisional licensure. LALD-A said the building was empty, and no other residents lived there prior to February 17, 2026. LALD-A said the licensee would move all resident's back to the prior location once they completed all repairs. The licensee failed to provide notice to MDH of providing services. TIME PERIOD OF CORRECTION: Two (2) days	0 180		
0 830 SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or	0 830		

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0 830	Continued From page 5 county. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a designated smoking area detached from the licensee's building in compliance with fire code and clean indoor air act. Within the designated smoking area (sunroom, attached to the dining room) contained smoldering cigarettes on the wood ledges below the window, and burn holes in the carpet. This deficient practice had the potential to cause a distinct hazard to life for all residents (R1, R2, R3, R4), staff and visitors. 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: Minnesota Clean Indoor Air Act, statutes 144.414, Prohibitions, indicated smoking is prohibited in a health care facility, except a resident of a health facility may smoke in a designated, separate, enclosed room in accordance with applicable state and federal laws. R1's diagnoses included schizoaffective disorder. R1's service plan dated January 1, 2026, indicated he required behavior management for	0 830		

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0 830	Continued From page 6 agitation, socialization, anxiety, orientation, psychosis, wandering, physical and verbal aggression, property and destruction. R1 required safety checks three times a day. R1's nursing assessment dated January 13, 2026, indicated he was able to smoke safely and able to dispose of his cigarettes in an ashtray or designated area. The assessment indicated there were no burn holes in the carpet or furniture. R2's diagnoses included bipolar disorder. R2's service plan dated February 18, 2026, indicated he required behavior management for required behavior management for agitation, socialization, anxiety, orientation, psychosis, wandering, physical and verbal aggression, property and destruction. R2 required safety checks three times per day. R2's nursing assessment dated March 3, 2026, indicated he did not smoke. R3 admitted into the licensee on March 3, 2026, for diagnoses including schizoaffective disorder, post-traumatic stress disorder (PTSD), and substance abuse disorder. R3's service plan dated March 3, 2026, indicated he required behavior management for required behavior management for agitation, socialization, anxiety, orientation, psychosis, wandering, physical and verbal aggression, property and destruction. R3 required safety checks three times per day. R3's nursing assessment dated March 16, 2026, indicated he did not smoke. R4's diagnoses included total brain injury (TBI) and epilepsy. R4's service plan dated February 2, 2023, indicated he required behavior	0 830		

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0 830	Continued From page 7 management for agitation, socialization, anxiety, orientation, wandering, and verbal aggression. R4 required safety checks three times per day. R4's nursing assessment dated February 14, 2026, indicated he was able to smoke safely and able to dispose of his cigarettes in an ashtray or designated area. The assessment indicated there were no burn holes in the carpet or furniture. On March 31, 2026, at 9:29 a.m., the surveyor entered the licensee's building. The surveyor observed the upper level contained a kitchen and dining area with glass doors connected to a "sunroom". Inside the sunroom, there were larger sized windows with pronounced window ledges located under the window. These ledges were covered with cigarette butts and ashes. The surveyor observed smoldering cigarette butts on the ledge. The surveyor observed ashes and burn holes in the carpet in under the window. Also, multiple burn holes in the carpet throughout the sunroom. There were cigarette butts scattered on the carpet of the sunroom. On March 31, 2026, at 10:53 a.m., the surveyor showed registered nurse (RN)-D the sunroom. RN-D acknowledged the fire hazard due to this behavior and said the residents should be smoking outside. RN-D said there were four residents currently living in the building. On March 31, 2026, at 11:58 a.m., the surveyor took licensed assisted living director (LALD)-A, who was also the owner, into the sunroom. There were two resident smoking inside the sunroom. LALD-A told the two residents to go outside. The surveyor showed LALD-A burn holes in the carpet, and smoldering cigarettes. LALD-A acknowledged the fire hazard associated with this	0 830		

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0 830	Continued From page 8 behavior. LALD-A told unlicensed personnel (ULP)-C who were present he required them to monitor resident smoking and have them smoke outside. On April 1, 2026, at 8:57 a.m., the surveyor sent an email to LALD-A and requested the licensee's smoking policy. No smoking policy was provided. On April 16, 2026, at 12: 03 p.m., LALD-A said the burn holes in the carpet were present prior to moving the residents into the building. LALD-A acknowledged there were cigarette butts on the carpet and on the window ledge. MG-A acknowledged there were smoldering unattended cigarettes on the window ledge. LALD-A acknowledged there was a fire hazard risk. LALD-A acknowledged R1 and R3 smoked inside the sunroom during the surveyor's on-site visit. LALD-A said he told the licensee's staff to make sure to have the residents smoke outside of the building. LALD-A acknowledged R3's nursing assessment did not accurately identify he smoked. TIME PERIOD OF CORRECTION: Two (2) days	0 830		
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 three of four residents reviewed (R1, R3, R4) were free from maltreatment.	02360		

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02360	Continued From page 9 Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and an 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		