Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL334267065M
Compliance #: HL334266648C

Date Concluded: March 16, 2026

Name, Address, and County of Licensee Investigated:
Harmony View Assisted Living
1420 2nd Street North
Sauk Rapids, MN 56379
Benton County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, 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 staff failed to provide necessary care and services to a resident with a history of drug abuse. The resident was later found dead of a drug overdose.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident's plan of care was not followed by facility staff after staff failed to verify the resident's whereabouts and the resident was found deceased. Staff incorrectly listed the resident as being out of the facility, but the wheelchair he needed for mobility was parked in front of his door at the time. Scheduled medications and services for the evening before and morning of his death were documented as not provided due to his absence from the facility, but facility staff failed to confirm the resident's whereabouts. The resident was discovered after a staff member realized he couldn't have left the facility because the wheelchair was near his door, and staff entered his room to find him dead.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case manager, the parole officer, and the primary care provider. The investigation included review of the resident records, death record, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed care and services at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included chronic obstructive pulmonary disease (COPD). The resident's service plan included assistance with behavior monitoring for anxiety, self-injurious behaviors, and sexually inappropriate behaviors three times per day, meal reminders three times per day and twice daily medication administration. The resident's assessment indicated the resident had a history of drug use and substance abuse. The resident required the use of a wheelchair for mobility due to generalized weakness.

A police report indicated 911 was called to the facility at 12:39 p.m. for a man not breathing with no pulse. When officers arrived, they noted the resident appeared to have been dead for "some time." Staff reported the last time they saw the resident was yesterday afternoon. An officer spoke with the resident's son who disclosed that the resident had a drug problem, and he wouldn't be surprised if the death was an overdose. Officers found hypodermic needles, other drug paraphernalia, a baggie of what was believed to be a controlled substance and a baggie with a clear rock substance that was believed to be methamphetamine. The staff member working that morning told officers she went to the resident's room around 8:00 a.m. to administer his medications but he didn't answer when she knocked on the door and when she opened the door, she didn't see him, so she left and figured he was out of the facility. A housekeeper pointed out to the staff member later that morning that the resident couldn't have been out of the building because his wheelchair was outside the door, so staff reentered his apartment and found him dead in the corner of the room by the bathroom.

The resident's medication administration record (MAR) indicated the evening before the resident was found dead, his medications were documented as declined and he was marked as out of the facility. The next day, the resident's morning medications were also documented as declined due to being out of the facility. Services scheduled for the evening prior to his death were not completed, and it was documented that the resident was out of the facility. Staff failed to verify the resident's whereabouts, failed to contact the registered nurse if the resident was out of the building and failed to notify the nurse of missed medication administration times.

The resident's death record indicated the cause of death was toxic effects of methamphetamine.

During an interview, unlicensed personnel (ULP) #1 stated she spoke to the resident the day before he died, and he complained of having a cold. ULP #1 stated she usually saw the resident every 30 minutes because he went outside frequently to smoke. ULP #1 stated when she came into work the afternoon the resident was found dead; staff reported that they hadn't seen the resident for a while and she noticed the resident's wheelchair was in the same spot it was when she had left work the day prior. ULP #1 stated the resident never left the facility without his wheelchair and staff should have checked on him knowing he was in his room and hadn't come out for a while.

During an interview, ULP #2 stated she was working the morning the resident was found dead and she was told by the overnight shift that the resident was out of the facility. ULP #2 stated she brought the resident his 8:00 a.m. medications and knocked on his door and when he didn't reply, she unlocked it and opened the door but didn't fully enter his room. ULP #2 stated she didn't see the resident, so she continued on with her shift. ULP #2 stated around 11:00 a.m., she was talking to a housekeeper about how they thought it was weird the resident's wheelchair was outside his door because he used it to get around and if he had left the building, he would have either taken it with him or left it parked by the entrance. ULP #2 stated she only worked part time at the facility for a few months but knew the resident's wheelchair would be in front of his room if he was in his room and she would expect other staff would know that. ULP #2 stated after talking to the housekeeper, she went back into the resident's room and this time went all the way in and into the bathroom where she found the resident face down on the floor. ULP #2 stated when she spoke with law enforcement, they figured the resident had died around 10 or 11 p.m. the night before. ULP #2 stated she didn't know how facility staff didn't notice the resident didn't come to meals or take his medications for over two shifts without going to check on him to see if he was ok.

During an interview, ULP #3 stated the resident didn't really go anywhere overnight and staff would know the resident was in his room if his wheelchair was in front of the door. ULP #3 stated if the resident left the building, he'd leave his wheelchair by the elevator or front door and would usually sign out in the book.

During an interview, the assisted living director stated the resident sometimes isolated himself and did not always sign out when he left the facility. The director stated the resident had a history of substance abuse and there had been some concern the resident was using substances, but nobody had seen him using drugs or seen any drug paraphernalia in the facility.

During an interview, the current RN stated she was on vacation when the incident happened and didn't have any firsthand knowledge. The current RN stated she had not observed the resident using or being under the influence of any drugs. The current RN stated staff should have notified the resident's family or the RN if he was gone overnight and hadn't told anyone he'd be gone and that staff should have fully entered the resident's room to check on him when they attempted to administer his medications as you wouldn't be able to see parts of the room without going around a corner.

During an interview, the former RN stated she wasn't updated that the resident did not get his morning or evening medications due to him being out of the facility and she would expect staff to notify nursing. The former RN stated she had not seen the resident use drugs at the facility, and didn't know if the resident was frequently gone overnight.

During an interview, a facility resident stated it was pretty obvious the resident was under the use of substances as the resident would sometimes come to meals all goofy and would sprawl out and make a mess and could barely walk.

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, deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

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
Benton County Attorney
Sauk Rapids City Attorney
Sauk Rapids Police Department
Minnesota Board of Nursing
Minnesota Board of Executives for Long Term Services and Supports
Medical Examiner
Minnesota Board of Medical Practice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33426	A. BUILDING: _____ B. WING _____	C 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VIEW ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

(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: #HL334267122M/ #HL334266684C #HL334267065M/ #HL334266648C On December 11, 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 17 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL334267122M/ #HL334266684C, tag identification 0620, 2310. The following correction orders are issued for #HL334267065M/ #HL334266648C, tag identification 0620, 2320, 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.	

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0 620	Continued From page 1	0 620		
0 620 SS=E	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.	0 620		

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0 620	Continued From page 2 (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) two instances of suspected maltreatment for two of two residents (R1, R2) reviewed for maltreatment. 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 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	0 620		

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0 620	Continued From page 3 found to be pervasive). The findings include: The licensee failed to immediately report suspected neglect after R1 and R2 died unexpectedly at the facility. R1 R1 was found dead in his room on September 14, 2025. Facility records indicated clinical nurse supervisor (CNS)-A was aware R1's friend called the facility seven times between 6:52 p.m. and 7:18 p.m., after she was notified by R1 that he fell and needed assistance, but no one at the facility answered the phone. A police report indicated R1 had called his girlfriend after falling because he did not have the facility number programed in his phone and he needed help. R1's girlfriend tried calling the facility multiple times to summon help for R1 but no one answered. The licensee failed to investigate the incident and failed to report the incident to MAARC. R1's diagnoses included type two diabetes, agoraphobia with panic disorder (fear of being in situations where escape may be difficult or help unavailable), borderline personality disorder, anxiety, schizoaffective disorder, and obsessive compulsive disorder. R1's record contained a partially completed incident report dated September 14, 2025, at 7:45 p.m., which noted R1 called his friend who then came running into the facility yelling that R1 fell and needed help. The friend reported R1 had been getting out of his wheelchair to get in bed when he fell. The incident report noted staff called	0 620		

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0 620	Continued From page 4 911 after the friend came running into the facility. Upon entering the room, R1 was found on his back laying in the middle of the bedroom floor. The resident was pronounced dead at 8:08 p.m. R2 R2 was found dead in his room on August 4, 2025. Facility records indicated R2 was found unresponsive on his bathroom floor. Clinical nurse supervisor (CNS)-A documented she was informed that methamphetamine and syringes were found in R2's room. R2's death record indicated the resident died on August 4, 2024, and the cause of death was toxic effects of methamphetamine. A police report indicated R2 had been dead for "some time" and the last time the resident was seen alive was the afternoon the day before. Staff reported to officers that R2's wheelchair had been in front of his room door, which meant he was in the facility, however they thought he wasn't in the facility and that was why no one had checked on him. A staff member discovered R2 dead after a housekeeper pointed out he likely was in his room. The licensee failed to investigate the incident and failed to report the incident to MAARC. On December 18, 2025, at 10:45 a.m., current CNS-A stated she was familiar with MAARC reporting but they felt since the police were investigating, that it wasn't needed to report the incident. On December 22, 2025, at 8:35 a.m., housing manager (HM)-F stated she had been trained on MAARC reporting but if it fell under a clinical line, like a resident death would, the nurse would be expected to submit the MAARC.	0 620		

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0 620	Continued From page 5 On December 22, 2025, at 11:50 a.m., licensed assisted living director (LALD)-E stated they had left the reporting to the police as they did not want to interfere with the investigation into R2's death. LALD-E stated in hindsight, they should have done a report. On December 24, 2025, at 11:20 a.m., former CNS-B stated she had been trained on MAARC reporting but was not sure if one was submitted for R2's death. CNS-B stated the nurse would generally be the one to submit a MAARC report. The licensee's Vulnerable Adult Maltreatment policy indicated any staff person who witnessed or suspected maltreatment would report the incident immediately to their supervisor, a nurse, or the assisted living director and that person would create an incident report. If the incident appeared to be suspected abuse, neglect, or financial exploitation, the licensed assisted living director would immediately make a report to the common entry point. Staff would then conduct an internal investigation. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	02310		

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02310	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure care and services were provided in accordance with accepted health care standards for one of one resident (R1) when staff failed to answer the facility phone after several calls were made to assist R1 during an emergency. R1 was found unresponsive in his room after a friend came to the facility to alert staff of an emergency when the calls made the facility went unanswered. 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 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's diagnoses included type two diabetes, agoraphobia with panic disorder (fear of being in situations where escape may be difficult or help unavailable), borderline personality disorder, anxiety, schizoaffective disorder, and obsessive compulsive disorder. R1's assessment dated July 30, 2025, indicated the resident had limited mobility due to a previous bilateral knee replacement, reported he was lightheaded most of the time, was unsteady when standing, and was at risk to be abused due to being a vulnerable adult and mental disorder and a disability. No interventions related to R1's vulnerabilities were listed. The resident had a	02310		

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02310	Continued From page 7 history of suicidial ideation, meth use, marijuana use, and alcohol abuse. The registered nurse (RN) documented she would monitor for any of these behaviors but did not identify any interventions. R1's service plan dated February 7, 2025, indicated R1 received assistance with bathing, toileting, grooming, transfers, behavior management, medication administration, and well being checks five times per day. R1's record contained a partially completed incident report dated September 14, 2025, at 7:45 p.m., which noted R1 called his friend who then came running into the facility yelling that R1 fell and needed help. The friend reported R1 had been getting out of his wheelchair to get in bed when he fell. The incident report noted staff called 911 after the friend came running into the facility. Upon entering the room, R1 was found on his back laying in the middle of the bedroom floor. The resident was pronounced dead at 8:08 p.m. R1's service recap summary for September 2025 indicated the resident declined a 6:00 p.m. toileting assistance and documented it as "self-administered" An earlier 2:30 p.m. behavior management service was marked as "Na" [not applicable]. R1's progress notes indicated on September 15, 2025, clinical nurse supervisor (CNS)-A was called in after R1 was found unresponsive in his room and she arrived to the facility at 8:25 p.m. CNS-A spoke with a police officer who was in R1's room with R1's girlfriend who stated CPR was performed but the resident was pronounced dead at 8:08 p.m. It was noted "Currently police are actively investigating." The medical examiner	02310		

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02310	Continued From page 8 came and retrieved R1's body and additional records were faxed to the medical examiner. Later that day, CNS-A was updated that R1's friend had called the facility at 6:52 p.m., 6:55 p.m., 6:59 p.m., 7:04 p.m., 7:07 p.m., 7:12 p.m., and 7:18 p.m. CNS-A called and updated the medical examiner's investigative team of the times of the phone calls. On December 11, 2025, R1's discharge assessment was requested. A discharge assessment dated December 11, 2025, was provided. The discharge assessment indicated R1 had died on September 14, 2025, and the cause of death was listed as unknown. R1's death record indicated the resident died on September 14, 2025, and the cause of death was listed as atherosclerotic and hypertensive cardiovascular disease. Significant conditions contributing to the death but not resulting in the underlying cause were mitragynine use and severe obesity. The death was noted to be accidental. R1's medical examiner report indicated a dietary supplement Kratom, which can cause effects similar to both opioids and stimulants, was present in R1's system, but the supplement was noted to be legal and widely available. A police report indicated 911 was called on September 14, 2025, at 7:30 p.m. for an unresponsive resident who possibly fell off the bed. R1 was observed laying on the floor against the bed with his head and neck propped up by the mattress. Rigor mortis had not set in and the officer placed an AED on the resident which advised starting chest compressions. Police and emergency medical services performed CPR for approximately 30 minutes until it was stopped	02310		

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(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
02310	Continued From page 9 after no signs of life were observed. Staff reported seeing R1 an hour prior. Two phones were observed on R1's bed. An officer opened the call log and noted several calls to [R1] cell and the facility from R1's girlfriend. One of the last calls on the phone was to R1's cell at 7:24 p.m., other calls were made at 7:18 p.m., 7:24 p.m.. The facility was called five times from 6:59 p.m. to 7:18 p.m. Officers interviewed R1's girlfriend who said she had been with R1 most of the day then left to go to the store to get some things and at some point she got a call from R1 saying he fell and he was scared. R1's girlfriend reported she tried to call staff at the building but no one answered, which officers confirmed was consistent with her call log. Officers reviewed R1's call log and saw he answered his phone for 21 seconds at 6:58 p.m. Officers interviewed unlicensed personnel (ULP)-D who said she and another ULP were working in the facility when R1's girlfriend rushed in and said R1 needed help. ULP-D reported she, the other staff member and the girlfriend went to R1's room and they found him lying on the floor. On December 16, 2025, at 1:20 p.m., ULP-J stated she had worked the day shift R1 died and the resident could get frustrated easily so if he called for help, you needed to come right away. ULP-J stated R1's blood pressure had been a bit high that day and she thought R1 screamed so much for help after he fell, he made his blood pressure go sky high and went into cardiac arrest. ULP-J stated when she returned to work after R1 died, another resident told her they could hear R1 screaming for help. ULP-J stated when R1 got a new phone, she offered to program the facility's phone number in it but he declined as he had to finish putting in some other numbers first. ULP-J stated she had raised concerns to management	02310		

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02310	Continued From page 10 about the call light system because if the call light was on for more than 30 minutes, it would automatically shut off, even if it hadn't been answered. On December 18, 2025, at 10:45 a.m., CNS-A stated staff had called her the evening R1 died to tell her paramedics had came and started CPR so she came to the facility. CNS-A stated R1's girlfriend had tried calling the facility and when no one answered, she came to the facility and alerted staff that something was wrong with R1. CNS-A stated she thought R1's girlfriend had called seven times with the last call at 7:18 p.m. CNS-A stated R1 had a call pendant but wasn't able to find it. On December 22, 2025, at 8:35 a.m., housing manager (HM)-F stated if the facility phone was on the charger, staff would not be able to hear it if they were in a resident's room or down the hall. HM-F stated staff would generally carry the facility phone but if it was left in the office or charging, staff wouldn't hear the phone ring if they were providing cares. On December 22, 2025, at 11:50 a.m., licensed assisted living director (LALD)-E stated he was previously not aware R1's girlfriend had made multiple calls to the facility that were not answered. LALD-E stated he thought R1's girlfriend had called after staff called 911 and hadn't answered the phone as she was attending to the emergent issue. LALD-E stated facility staff should answer the phone. On December 22, 2025, at 2:50 p.m., R1's girlfriend stated she had been with R1 most of the day and he had complained of chest pains but didn't want to tell the staff as he didn't want to go	02310		

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02310	Continued From page 11 back to the hospital. R1's girlfriend stated later that afternoon, she left and when she talked to him after she got home, he said he had fallen and needed help. R1's girlfriend stated she tried calling the facility multiple times but no one answered the phone and that was common for staff to not answer the phone in the evenings. R1's girlfriend stated R1 called her a second time and said he was really scared and needed help so she went to the facility and she and a staff member found him unresponsive in his room and 911 was called. R1's girlfriend stated R1 did have a call pendant but he would sometimes lose it or not have it on him and that was why he called her for help. R1's girlfriend stated management knew staff wouldn't answer the phone after the office managers left because they could see it on facility cameras. On December 23, 2025, at 8:45 a.m., case manager (CM)-H stated the facility did not immediately update her that R1 had died and she was not previously aware calls for help to the facility were not answered. CM-H stated R1 was recently in the hospital and she had concerns with the facility being able to meet R1's care needs from a staffing perspective but LALD-E had assured her the facility could meet R1's needs. On December 23, 2025, at 9:20 a.m., ULP-D stated she was working the evening shift when R1 died and earlier in the day, R1 seemed fine. ULP-D stated the other staff person would have had the facility phone but was not sure if she had it with her or not but she could not recall hearing the phone ring. ULP-D stated she heard a lady talking to her coworker [ULP-I] and she heard her say she needed help with R1 he's not responding so she ran upstairs while ULP-I and R1's girlfriend took the elevator. ULP-D stated she	02310		

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02310	Continued From page 12 went into R1's room and he was laid out on the floor and did not have his call pendant with him. ULP-D stated she ran downstairs to call 911. On December 23, 2025, at 9:35 a.m., ULP-I stated she was working the evening shift when R1 had died but she would normally work overnights. ULP-I stated she had been doing laundry on the first floor and heard the phone ringing but she didn't know it was a resident calling as sometimes calls can be spam. ULP-I stated if it was a call light, she would have responded immediately. ULP-I stated she couldn't recall if she answered the phone and spoke to R1's girlfriend on the phone or if she spoke to her in person when she arrived at the facility. ULP-I stated she thought she had answered the phone but couldn't recall as it had been a few months since the incident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	02310		
02320 SS=G	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the	02320		

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02320	Continued From page 13 licensee failed to provide appropriate health care services from people who were properly trained and competent when there was no system in place to ensure appropriate assessment and monitoring were provided by facility staff. Facility nursing staff failed to determine if a resident had left the facility and failed to update the nurse when medications were not able to be administered as prescribed for one of one (R2) resident reviewed. 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 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: R2's diagnoses included chronic obstructive pulmonary disease (COPD). R2's service plan dated March 14, 2024, indicated the resident received services including a three times per day behavior management for anxiety, self injurious behaviors, and sexually inappropriate behavior, three times per day meal reminders, and twice daily medication administration. R2's assessment dated May 9, 2025, indicated R2 required the use of a wheelchair for mobility due to generalized weakness. The assessment did not address if R2 signed out of the facility for outings. R2's discharge assessment completed on	02320		

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02320	Continued From page 14 September 3, 2025, included the following, "...He frequently went out during the day with friends but did not consistently sign the sign-out binder. The resident was found unresponsive on the bathroom floor. EMS and the investigator were notified and responded. Initially, it was communicated that the body would be released to the funeral home by investigator [name]. Later that day, the investigator informed that methamphetamine and syringes were discovered in the resident's room. As a result, the medical examiner was contacted and took the body for further investigation. All medication was sent with the medical examiner." R2's progress notes only included one note about an out of range blood pressure on May 6, 2025. R2's progress notes lacked any documentation on his death or if he had been out of the facility. R2's service recap summary and medication administration record for August 2025 indicated the evening of August 3, 2025, the resident's medications were documented as declined due to being out of the facility. Documentation of services provided indicated staff provided some services however some services were documented as not completed due to the resident being out of the facility. R2's medications and services were all declined on the day shift of August 4, 2025 due to being out of the facility. A police report indicated 911 was called on August 4, 2024, at 12:39 p.m. for a man not breathing with no pulse. When officers arrived, two staff members were with the resident and it appeared R2 had been dead for "some time." Staff reported the last time they saw R2 alive was yesterday afternoon. An officer spoke with R2's son who disclosed that R2 had a drug problem	02320		

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02320	Continued From page 15 and he wouldn't be surprised if the death was an overdose. An officer found a tin on the resident's bed which had hypodermic needles and a blue rubber band that "looked like it was used to tie off when using hypodermic needles." A spoon with white residue and a Ziploc bag with white residue was observed. The officer believed it to be a controlled substance and the materials were consistent with using controlled substances. A small baggie with a clear rock lick substances was observed and believed to be methamphetamine. The officer confirmed with R2's family member that the resident was an amphetamine user. An officer spoke with ULP-C who reported she worked August 3rd and August 4th and on August 3rd, R2 reported not feeling well and she told him to tell the staff member working on the second floor and she did not see R2 again after that conversation. Unlicensed personnel (ULP)-C reported around 8:00 a.m. that day, she knocked on R2's door and he didn't answer so she opened his locked door with a key and called for R2 to take his medications. When R2 did not reply and she didn't see him in bed, she assumed he was out of the facility. ULP-C reported locking his door and going about her rounds. ULP-C stated a housekeeper had asked her if anyone had seen R2 and ULP-C stated she thought he was gone out of the facility. The housekeeper pointed out R2's wheelchair was in the hallway and that if he was going out of the facility, he'd take his wheelchair. ULP-C agreed that he would have taken his wheelchair so she went back to his room to check on him. ULP-C found R2 after entering his room and going around the corner and called for help and CNS-B came to R2's room. Clinical nurse supervisor (CNS)-B told officers she didn't work August 3rd but there were notes from the two previous shifts that R2 was marked as out of the facility.	02320		

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02320	Continued From page 16 R2's death record indicated the resident died on August 4, 2024, and the cause of death was toxic effects of methamphetamine. Significant conditions contributing to the death but not resulting in the underlying cause was noted to be hypertensive and arteriosclerotic heart disease. R2's medical examiner report indicated toxicology studies confirmed the presence of methamphetamine and an associated metabolite (amphetamine). Methamphetamine was noted to be a psychostimulant drug that could produce fatal cardiac arrhythmias, hypertension, and cardiac ischemia. On December 18, 2025, at 11:20 a.m., ULP-C stated she was working the day shift R2 was found dead and had been told by the overnight shift that the resident was out of the facility. ULP-C stated she brought R1's medications around 8:00 that morning and knocked on his door and when he didn't reply she unlocked and opened the door but didn't enter his room. ULP-C stated she didn't see R2 so she continued on with her shift. ULP-C stated around 11:00 a.m., she was talking to a housekeeper about how they thought it was weird R2's wheelchair was outside his door because he would use that to get around and if he had left the building, he would have either taken it with him or left it parked by the entrance. ULP-C stated she had only worked part time at the facility for a few months and she knew R2's wheelchair would be in front of his room if he was in his room and she would expect other staff to know that as well. ULP-C stated after talking with the housekeeper about how it was odd the wheelchair was by R2's door, she went back into his room and this time went all the way in and into the bathroom where she found him face down on the floor. ULP-C stated when she spoke with law	02320		

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02320	Continued From page 17 enforcement they figured R2 had died around 10 or 11 p.m. the night before. ULP-C stated she didn't know how facility staff didn't notice he didn't come to meals or take his medications for two shifts without going to check on him to see if he was ok. On December 22, 2025, at 8:35 a.m., housing manager (HM)-F stated she knew R2 had a past history of using drugs but that was the extent of her knowledge. HM-F stated sometimes R2 would seem a little off but she knew R2 was also on probation so thought they might do drug testing. HM-F stated R2 would be gone overnight maybe once a month or maybe a few times a year and R2 was very independent. On December 22, 2025, at 11:50 a.m., licensed assisted living director (LALD)-E stated R2 would sometimes isolate himself and he would not always sign out when leaving the facility. LALD-E stated R2 had a history of substance abuse and there had been some concern R2 was using substances but nobody had seen him using drugs or seen any drug paraphernalia in the facility. LALD-E stated since the incident happened, staff have been trained to enter a resident's apartment all the way when bringing medications or doing a safety check. On December 22, 2025, at 12:25 p.m., R2's case manager (CM)-G stated she recalled the facility reaching out to her with inklings R2 was using drugs but they didn't have any proof so it was more speculation. CM-G stated she was not updated by the facility that police had found controlled substances and paraphernalia in R2's room after his death and only knew that R2 had died.	02320		

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02320	Continued From page 18 On December 23, 2025, at 9:30 a.m. ULP-G stated R2 didn't really go anywhere overnight and staff would know R2 was in his room if his wheelchair was in front of the door. ULP-G stated if R2 left the building, he'd leave his wheelchair by the elevator or front door and would usually sign out in the book. On December 24, 2025, at 11:20 a.m., former CNS-B stated R2 was fairly independent and sometimes he would sign out if he left the building but sometimes he would not. CNS-B stated if R2 had been gone a long time, nursing should be updated. CNS-B stated from what she could recall, there weren't any concerns that R2 had not been seen since the day prior. CNS-B stated if staff were bringing R2 medications, they should go and see the resident and if medications weren't able to be given, they should have updated the nurse. CNS-B stated she was made aware that police found drugs in R2's room but they did not do any further investigation since police were investigating it. CNS-B stated from what she could recall, she had not observed R2 using drugs at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
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	02360		

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02360	Continued From page 19 by: The facility failed to ensure two of two residents reviewed (R1, R2) were 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		