Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL349204248M
Compliance #: HL349203931C

Date Concluded: October 26, 2026

Name, Address, and County of Licensee Investigated:
SMC Ashton
6242 Larch Lane North
Maple Grove, MN 55369
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, RN
Special Investigator
Rhylee Gilb, 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 financially exploited the residents (resident 1, resident 2, resident 3 and resident 4) when they received the residents' additional Medicaid funds without a care need.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The facility was responsible for the maltreatment. The facility acquired Medicaid funds of resident 1, resident 2, resident 3 and resident 4 through fraud by requesting and receiving payment for services the residents did not require. Additionally, the facility failed to use resident 1, resident 2, resident 3 and resident 4's Medicaid funds to provide services the facility attested they would provide, for their financial gain, by not scheduling enough staffing coverage to provide all the hours of individual services each resident required.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records, county waiver records, staff schedules, staffing shift logs, and related facility policy and procedures. Also, the investigator observed the physical environment and if care was provided.

The residents resided in an assisted living facility.

Resident 1
Resident 1's diagnoses included several mood disorders and personality disorders. Resident 1's assessed evacuation status indicated resident 1 required cues to evacuate.

Resident 1's customized living worksheet (6790 form), completed by the facility and submitted to the case manager for payment of services included the following individual daily services and time required to complete the service:
-0.75 hours per day of homemaking
-0.28 hours per day of assistance making appointments
-2 hours per day one staff to one resident (1:1) socialization
-0.4 hours per day assistance with dressing
-0.4 hours per day assistance with grooming
-0.4 hours per day assistance with bathing
-1 hour per day assistance with self-administration
-0.75 hours per day of verbal or visual medication reminders
-0.5 hours per day of medication set ups and monitoring
-2 hours a week (0.28 hours per day) of money management
-1.5 hours per week (0.21 hours per day) delegated clinical monitoring (notes indicated the nurse would assess resident 1 daily due to electroconvulsive therapy (ECT))
-0.14 hours per day other delegated tasks-list services in note field (notes indicated vital signs checked twice daily)
-0.4 hour per day assistance with walking (hands on and stand by assist for support)
-2 hours per day to manage orientation issues
-2 hours per day to manage anxiety
-1.5 hours per day to manage repetitive behavior
-2 hours per day to manage agitation
-0.5 hours per day to manage verbal aggression
-1 hour per day to meet other cognitive/mental health need 1: (notes indicated manage symptoms of psychosis, dependent personality disorder)
-1 hour per day to meet other cognitive/mental health need 2: (notes indicated manage symptoms of obsessive-compulsive disorder)
Totaling 17.51 hours per day of individual daily services.

Resident 1's service plan failed to include managing wandering as required by the 6790.

Resident 1's assessment indicated she was oriented to person, place, and occasionally required redirection due to mild disorientation. Resident 1 required dressing, bathing and grooming reminders but dressed, bathed and groomed himself. Resident 1's usual bedtime was 10:00 p.m. Resident 1 was independent with mobility and walking, contradictory of having a service for hands on walking.

The licensee failed to complete resident 1's vital signs daily as required by the 6790. Two months of records had no vital signs record. One day a note indicated "unable to obtain vitals."

Resident 1's service delivery record failed to include daily homemaking, walking assistance and daily management of resident 1's orientation, wandering, repetitive behaviors, dependent personality disorder, or obsessive-compulsive disorder. Without the required services on the record, unlicensed personnel (ULP) were not directed to complete those services.

The facility fraudulently received resident 1's Medicaid benefit funds for services she did not require, that included managing orientation issues daily, making daily appointments, assistance with dressing, grooming, bathing and walking. The facility failed to use her funds appropriated for services and did not provide 1:1 socialization, daily homemaking, managing behaviors of repetitive behaviors, dependent personality disorder, or obsessive-compulsive disorder.

During an interview, resident 1 stated the facility did not provide activities. Resident 1 stated he made her own medical appointments and scheduling transportation. Resident 1 stated he biked or called for transportation if he wanted to go anywhere. Resident 1 stated he made his own bed sometimes, took out his own garbage and did his own laundry. Resident 1 stated he was independent with dressing, grooming, walking and showering.

Resident 2

Resident 2's diagnoses included neurodivergent disorders, several mood/personality disorders, and post-traumatic stress disorder. Resident 2's assessed evacuation status indicated resident 2 was self-sufficient, able to walk and require no to minimal nursing care.

Resident 2's customized living worksheet (6790 form), completed by the facility and submitted to the case manager for payment of services included the following individual daily services and time required to complete the service:

-0.75 hours per day of daily homemaking
-0.36 hours per day of daily shopping
-0.28 hours per day of money management
-1.5 hours per week assistance making appointments
-2 hours per day of 1:1 socialization
-0.14 hours per day assistance with grooming (notes indicated: cues and reminders)
-0.07 hours per day for assistance with dressing (notes indicated: cues and reminders)
-0.07 hours per day for bathing (notes indicated: reminders to take bath once daily)
-0.5 hours per day of medication set ups and monitoring

-0.75 hours per day assistance with self-administration
-0.25 hours per day for verbal or visual medication reminders
-1.5 hours a day to manage anxiety
-1 hour per day to manage agitation
-1 hour per day to manage verbal aggression
-1 hour per day to meet other cognitive/mental health need 1: (note section indicated: see behavior plan)
-1 hour per day to meet other cognitive/mental health need 2: (note section indicated: see behavior plan)
-1 hour per to meet other cognitive/mental health need 3: (note section indicated: see behavior plan)
Totaling 13.17 hours per day for individual daily services.

Resident 2's 6790 behavior plan indicated mental health need 1 required management of symptoms of attention deficit hyperactivity (ADHD) disorder, mental health need 2 required management of symptoms of bipolar disorder and mental health need 3 required management of socially unacceptable behavior. Interventions included staff supervision when resident 2 was in the community and 1:1 staff engagement for redirection.

Resident 2's assessment indicated resident 2 was oriented to person, place, and time. Resident 2 occasionally need redirection due to mild disorientation to person, place and time. Resident 2 required cues and reminders for dressing, grooming and bathing. Resident 2 required assistance in the community during planned outings.

Resident 2's service plan accurately reflected the services of the 6790 form. Resident 2 required assistance with medication administration.

Resident 2's service delivery records failed to include daily homemaking, managing repetitive behaviors, symptoms of ADHD and bipolar disorder.

The facility fraudulently received resident 2's Medicaid benefit funds for services he did not require, that included a duplicative service for medication reminders when he received assistance with medication administration and daily homemaking. The facility failed to use his funds appropriated for services and did not provide 1:1 staff in the house and 1:1 staff in the community to prevent incidents related to mental health behaviors.

During an interview, resident 2 stated he emptied his own garbage, did not receive help with making his bed, vacuumed his own floor, and did his own laundry. Resident 2 stated he was independent with dressing, grooming, and bathing. When asked if staff spent 1:1 time with him, resident 2 stated if he asked staff too, they would. Resident 2 stated he used his gas motor bike to go out into the community.

Resident 3

Resident 3's diagnoses included schizophrenia, bipolar disorder and cannabis and stimulant abuse. Resident 3 required verbal cueing in an evacuation.

Resident 3's customized living rates worksheet (6790 form) completed by the facility and submitted to the case manager for payment of services included the following individual daily services and time required to complete the service:
-0.75 hours of homemaking
-0.14 hours per day of daily shopping
-0.25 hours per day of assistance making appointments
-2 hours per day of 1:1 socialization
-0.14 hours per day assistance with dressing with stand by physical assistance as needed for dressing
-0.14 hours per day of assistance with grooming (notes indicated: staff remind and encourage to groom daily)
-0.14 hours per day assistance with bathing (prompts to bathe daily)
-0.5 hours per day assistance with self-administration
-0.5 hours per day verbal or visual medication reminders
-0.5 hours per day of medication set ups and monitoring
-0.14 hours per day of money management
-5 hours per week (0.71 hours per day) managing orientation
-5 hours per week (0.71 hours per day) managing anxiety
-3 hours per week (0.43 hours per day) to manage repetitive behaviors
-2.5 hours per week (0.36 hours per day) to manage self-injurious behaviors
-2 hours per day to manage verbal aggression
-2 hours per week (0.28 hours per day) managing wandering
-3.5 hours per week (0.5 hours per day) managing agitation
-1 hour per day to meet other cognitive/mental health need 1: (notes indicated: social withdrawal, depression, and isolation)
-1 hour per day to meet other cognitive/mental health need 2: (notes indicated: psychosis, paranoia, delusion, and hallucination)
-1 hour per day to meet other cognitive/mental health need 3: (notes indicated: managing polysubstance abuse-meth-cannabis)
Totaling 13.19 hours per day of individual daily services.

Resident 3’s behavior plan on the 6790 indicated staff were required to provide 1:1 staffing at the facility and in the community for resident 3’s self-injurious behaviors and other mental health needs. The behavior plan indicated resident 3 required assistance with wandering and the facility was secured with alarms at exits.

However, resident 3’s assessment indicated he was oriented to person, place and time. Resident 3’s elopement risk assessment indicated a score of not at risk for elopement and resident 3 was not required to have supervision leaving. Resident 3 required cues and

reminders for dressing, grooming and bathing. Resident 3 required assistance in the community during planned outings.

Resident 3's service plan failed to include managing resident 3's mental health need 1: social withdrawal, depression, isolation and mental health need 2: psychosis, paranoia, delusion, hallucinations. Resident 3 required assistance with medication administration.

Resident 3’s service delivery record failed to include daily homemaking and management of resident 3's wandering, orientation issues, repetitive behavior, social withdrawal, depression, isolation, or polysubstance abuse.

During an onsite observation, resident 3 did not have 1:1 staff. The facility did not have alarms at exits.

The facility fraudulently received resident 3’s Medicaid benefit funds for services he did not require, that included a duplicative service for medication reminders when he received assistance with medication administration and managing wandering. The facility failed to use his funds appropriated for services including daily homemaking, managing orientation issues, repetitive behaviors, polysubstance abuse and social withdrawal, depression and isolation. The facility did not provide 1:1 staff in the house and 1:1 staff in the community to prevent incidents related to mental health behaviors.

Resident 4
Resident 4's diagnoses included multiple mood and personality disorders, diabetes and substance abuse. Resident 4’s assessed evacuation status indicated resident 4 was self-sufficient, able to walk and require no to minimal nursing care.

Resident 4's customized living rates worksheet (6790 form) completed by the facility and submitted to the case manager for payment of services included the following individual daily services and time required to complete the service:
-1 hour per day of homemaking
-0.33 hours per day of shopping
-0.14 hours per day of assistance making appointments
-2 hours per day of 1:1 socialization
-0.07 hours per day of assistance with dressing (prompts)
-0.07 hours per day of assistance with grooming (prompts and encourage)
-0.14 hours per day of assistance with bathing (prompts and encourage)
-0.75 hours per day to assistance with self-administration
-0.5 hours per day of verbal or visual medication reminders
-0.75 hours per day of insulin injections (note section indicated: staff were required to check his blood sugars three times daily and administer his insulin via flex pens. Resident 4 required "100%" support to manage his blood sugars)

-0.28 hours per day for insulin draws (note section: RN would conduct a bi-weekly assessment of resident 4's blood sugars)
-0.14 hours per day of money management
-1 hour per day to manage orientation issues
-1 hour per day to manage anxiety
-1 hour per day to manage repetitive behavior
-5 hours per week (0.71 hours per day) to manage self-injurious behaviors
-1 hour per day to manage verbal aggression
-2 hours per week (.28 hours per day) to manage property destruction
-1 hour per day to meet other cognitive/mental health need 1: (notes indicated: managing symptoms of delusions and disorganized behaviors)
-1 hour per day to meet other cognitive/mental health need 2: (notes indicated: managing schizophrenia)
-1 hour per day to meet other cognitive/mental health need 3: (notes indicated: managing symptoms of PTSD and ADHD)
Totaling 19.17 hours per day for individual daily services.

Resident 4’s behavior plan on the 6790 indicated 1:1 staff engagement to keep resident 4 at baseline to manage symptoms of anxiety, property destruction, self-injurious behaviors, orientation issues, repetitive behaviors, delusions and hallucinations.

Resident 4's assessment indicated resident 4 was oriented to person, place, and time. The assessment indicated an increase in substance use has led to resident 4's disorientation of time/place. Resident 4 required cues and reminders for dressing, grooming and bathing. Resident 4 required assistance in the community during planned outings.

Resident 4's service plan failed to include assistance with dressing, managing resident 4's mental health need 2: psychosis, paranoia, delusion, hallucinations and mental health need 3: managing symptoms of PTSD and ADHD. Resident 4 required assistance with medication administration.

Resident 4’s service delivery record failed to include daily housekeeping and management of orientation, anxiety, repetitive behaviors, property destruction, symptoms of ADHD, symptoms of PTSD, and symptoms of schizophrenia.

The facility fraudulently received resident 4’s Medicaid benefit funds for services resident 4 did not require included a duplicative service for medication reminders when he received assistance with medication administration, and daily homemaking. The facility failed to provide management of resident 4’s orientation, anxiety, repetitive behavior, property destruction, symptoms of PTSD, symptoms of ADHD, and symptoms schizophrenia. The facility failed to provide 1:1 socialization and staffing for behavior management. The facility failed to provide daily or weekly shopping assistance.

During an interview, resident 4 stated the facility staff took him shopping twice per month. Resident 4 stated he cleaned his own room, took out his own garbage and did his own laundry. Resident 4 was independent with dressing, grooming and bathing. Resident 4 stated staff did not spend 1:1 time with him and the facility did not have daily activities.

The facility staff schedule and time card logs indicated the facility staffed one staff per shift on morning, afternoon and night shift.

The total number of resident individual services required each day was 63 hours compared to 24 hours of staff available each day to provide services.

During the onsite visit, there was only one ULP working.

During an interview, the nurse stated they determine the services for residents prior to admission. The nurse stated the LALD and the facility manager completed and submitted the customized living worksheets to the residents' case managers.

In conclusion, the Minnesota Department of Health determined financial exploitation 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.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: Yes, resident 1, resident 2 and resident 4, attempted resident 3.
Family/Responsible Party interviewed: Not applicable.
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
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department
Minnesota Board of Executives for Long Term Services and Supports
MN Department of Human Services, Office of Inspector General, Surveillance Integrity Review Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34920	A. BUILDING: _____ B. WING _____	C 08/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMC ASHTON HOMES LLC	6242 LARCH LANE NORTH MAPLE GROVE, MN 55369

(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: HL349204248M/HL349203931C On August 28, 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 four residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL349204248M/HL349203931C, tag identification 1640, 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 oMinnesota Department of Health is documenting the State Correction Orders using federal software. Tag ut 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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01640	Continued From page 1	01640		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to implement and provide all services within the service plan and county waiver services for four of four residents (R1, R2, R3, R4) with records reviewed. The licensee failed to provide identified services to R1, R2, R3, R4. 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	01640		

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01640	Continued From page 2 cause serious injury, impairment, or death) and was 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: Upon entrance and exit of the licensee on August 28, 2026, the doors did not observe to be armed with alarms R1 R1 admitted to the licensee on April 22, 2022. R1's diagnoses included schizoaffective disorder, bipolar, dependent personality disorder, anxiety disorder, obsessive compulsive disorder, unspecified psychosis not due to a substance or known physiological condition. R1 required cues if needed in case of evacuation. R1's customized living rates worksheet (commonly known as 6790) dated December 4, 2025, was written by the licensee and submitted to case manager (CM) for payment of services March 1, 2026, through February 28, 2027. The worksheet indicated the licensee would provide the following services which included time to complete: -0.75 hours per day of homemaking (not section indicated: R1 relied on staff for all housekeeping needs. Sweeping, washing dishes, and tidying daily. Vacuuming would be done daily. Daily staff support in cleaning and organizing his bedroom) -0.28 hours per day assistance making appointments -2 hours per day one staff to one resident (1:1) socialization -0.4 hours per day assistance with dressing (note section indicated 1:1 standby when dressing)	01640		

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01640	Continued From page 3 -0.4 hours per day assistance with grooming (note section indicated 1:1 standby when grooming) -0.4 hours per day assistance with bathing (prompts, cueing, and 1:1 standby assist when showering) -1 hour per day assistance with self-administration -0.75 hour per day of verbal or visual medication reminders -0.5 hours per day of medication set ups and monitoring -2 hours a week (0.28 hours per day) of money management -1.5 hours per week (0.21 hours per day) delegated clinical monitoring (note section: the RN would assess R1 daily due to electroconvulsive therapy (ECT)) -0.14 hours per day other delegated tasks-list services in note field (note section: vital signs were checked twice daily) -0.4 hour per day assistance with walking (hands on and stand by assist for support) -2 hours per day to manage orientation issues -2 hours per day to manage anxiety -1.5 hours per day to manage repetitive behavior -2 hours per day to manage agitation -0.50 hours per day to manage verbal aggression -1 hour per day to meet other cognitive/mental health need 1: (notes indicated: manage symptoms of psychosis, dependent personality disorder) -1 hour per day to meet other cognitive/mental health need 2: (notes indicated: manage symptoms of obsessive-compulsive disorder) Totaling 17.51 hours per day of individual daily services. R1's 6790 behavior plan included managing R1's orientation issues (1:1 to engage in structured	01640		

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01640	Continued From page 4 activities to keep R1 calm), symptoms of anxiety (one on one engagement keeps R1 at his baseline), repetitive behavior (one on one engagement keeps R1 at his baseline), agitation, verbal aggression, dependent personality disorder, and obsessive-compulsive disorder. R1's service plan dated December 4, 2025, indicated R1 required the following services: -homemaking three times daily -shopping once per week -assistance making appointments once weekly -money management as needed -socialization 1:1 daily -dressing assistance no frequency, cues, reminders, assist as needed -grooming assistance no frequency, cues and reminders, assist as needed -bathing assistance no frequency, cues and reminders, assist as needed -walking assistance no frequency, stand by assist when feeling tired or unsteady; prone to trips/falls -med administration or assistance with self-administration twice daily -verbal or visual medication reminders with no frequency -med set ups, monitoring and related tasks once daily, medication set up weekly, but medication monitored and managed daily. -delegation clinical monitoring, no frequency, assess monitor effectiveness of ECT treatment on mood and overall, well being -other delegated tasks no frequency, licensee did not identify -manage agitation daily -manage orientation issues, no frequency -manage anxiety, no frequency -manage repetitive behavior, no frequency -manage agitation, no frequency -manage verbal aggression, no frequency	01640		

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01640	Continued From page 5 -meet other cognitive/mental health need 1: (notes indicated: manage symptoms of psychosis, dependent personality disorder) no frequency -meet other cognitive/mental health need 2: (notes indicated: manage symptoms of obsessive-compulsive disorder) no frequency R1's service plan did not include managing wandering. R1's assessment dated August 6, 2026, indicated R1's usual bedtime was 10:00 p.m. R1 required bathing reminders and bathed himself. R1 required verbal reminders and groomed himself. R1 was independent with ambulation/mobility. R1 was oriented to person, place, time, and situation. R1 occasionally required redirection with mild disorientation to person, place, time. R1's vital signs record for July and August 2026, indicated R1 had no vital signs checked. The one occasion of documentation on record for this date range was on August 14, 2026, which indicated "unable to obtain vitals". R1's service delivery record for August 2026, did not include daily homemaking or walking assistance The same record did not include daily management of R1's orientation, wandering, repetitive behaviors, dependent personality disorder, or obsessive-compulsive disorder. The licensee inappropriately requested county payments for services R1 did not require, including assistance with walking, dressing, grooming, bathing, managing orientation issues and making daily appointments. The licensee failed to provide 1:1 socialization, daily homemaking, managing behaviors of repetitive	01640		

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	34920	A. BUILDING: _____ B. WING _____	C 08/28/2026

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01640	Continued From page 6 behaviors, dependent personality disorder, or obsessive-compulsive disorder. During an interview, on August 28, 2026, at 9:10 a.m., R1 stated he made 90 percent of his own medical appointments and set up 80-90% of his own medical rides. He said he had transportation plus and called blue ride for appointments. R1 stated he purchased his own breakfast sandwiches and made himself a sandwich for breakfast in the microwave. R1 stated staff were very different with cooking, some cook all the time, others do not cook for them. R1 stated generally speaking, staff would prefer them to make their own meals, and some expect them to cook for themselves. R1 stated he brought out his own trash, made his own bed, and did his own laundry. R1 stated he was independent with dressing, grooming, walking, and showering. R1 stated the licensee did not have daily activities. When asked if staff spent 1:1 time with him, he stated he spoke to staff all the time. R1 stated he biked or called for transport himself if he wanted to go anywhere. R2 R2 admitted to the licensee on August 30, 2024. R2's diagnoses included Aspergers, attention deficit hyperactivity disorder, bipolar disorder, borderline personality disorder, anxiety disorder, oppositional defiant disorder and post-traumatic stress disorder. The licensee identified R2's evacuation status as level 1: self-sufficient, ambulatory, and requiring no or minimal nursing care. R2's customized living rates worksheet (commonly known as 6790) dated November 4, 2025, was written by the licensee and submitted	01640		

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01640	Continued From page 7 to CM for payment of services November 1, 2025, through October 31, 2026. The worksheet indicated the licensee would provide the following services which included the time to complete: -0.75 hours per day of daily homemaking (assist R2 with sweeping, washing dishes, and tidying daily. Mopping would be done daily and as needed) -0.36 hours per day of daily shopping -0.28 hours per day of money management -1.5 hours per week assistance making appointments -2 hours per day of one staff to one resident (1:1) socialization -0.14 hours per day assistance with grooming (note section: cues and reminders) -0.07 hours per day for assistance with dressing (note section: cues and reminders) -0.07 hours per day for bathing (note section: reminders to take bath once daily) -0.5 hours per day of medication set ups and monitoring -0.75 hours per day assistance with self-administration -0.25 hours per day for verbal or visual medication reminders -1.5 hours a day to manage anxiety -1 hour per day to manage agitation -1 hour per day to manage verbal aggression -1 hour per day to meet other cognitive/mental health need 1: (note section indicated: see behavior plan) -1 hour per day to meet other cognitive/mental health need 2: (note section indicated: see behavior plan) -1 hour per to meet other cognitive/mental health need 3: (note section indicated: see behavior plan) Totaling of 13.17 hours per day for individual daily services.	01640		

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01640	Continued From page 8 R2's 6790 behavior plan indicated staff managed R2's symptoms of agitation, verbal aggression, repetitive behavior (1:1 engagement helped R2 keep at his baseline), need 1: symptoms of attention deficit hyperactivity (ADHD) disorder (1:1 engagement helped R2 keep at his baseline), need 2: symptoms of bipolar disorder (staff spend short, frequent 1:1 time with R2 during the day and R2 experienced disorganized thinking and auditory hallucinations), need 3: socially unacceptable behavior (sexual addiction) (staff spend 1:1 support to R2 to distract him from hypersexual-seeking behaviors, 1:1 time to talk about things he was interested in, prompt R2 2-3 times to engage in activities, and staff supervise R2 when out in community). R2's assessment dated May 14, 2026, indicated R2 was oriented to person, place, time, and situation. R2 occasionally needed redirection due to mild disorientation to person, place, and time. R2 required cues and reminders for dressing, grooming and bathing. R2 required assistance in the community during planned outings. R2's service plan dated March 23, 2026, indicated R2 required the same services as the 6790. R2 required assistance with medication administration. R2's service delivery record for August 2026, did not include did not include daily homemaking, managing R2's repetitive behavior, symptoms of ADHD, or bipolar disorder. The licensee inappropriately requested county payments for services R1 did not require, that included a duplicative service for medication reminders when he received assistance with	01640		

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01640	Continued From page 9 medication administration and daily homemaking. The licensee failed to provide 1:1 staff in the house and 1:1 staff in the community to prevent incidents related to mental health behaviors. During an interview on August 28, 2026, at 10:21 a.m., R2 stated a couple of staff members do not cook at all. R2 stated he emptied his own garbage, did not receive help with making his bed, vacuumed his own floor, and he did his own laundry. R2 stated he was independent with dressing, grooming, and bathing. When asked if staff spend 1:1 time with him, R2 stated if he asked staff too, they would. R2 stated there was not daily activities at the licensee. R2 stated he used his gas motor bike to go out into the community. R3 R3 admitted to the licensee March 10, 2020. R3's diagnoses included schizoaffective disorder, bipolar disorder, cannabis and other stimulant abuse. R3's customized living rates worksheet (commonly known as 6790) dated December 25, 2025, was written by the licensee and submitted to CM for payment of services December 1, 2026, through December 31, 2026. The worksheet indicated the licensee would provide the following services which included the time to complete: -0.75 hours of homemaking (note section indicated: assist R2 with sweeping, vacuuming, washing dishes and disinfect services. R3 struggled with keeping his room clean and staff assist with removing, trash, dirty dishes, organizing his room daily. R3 constantly smoked in his room and there was cigarette litter everywhere. Staff did R3's laundry)	01640		

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01640	Continued From page 10 -0.14 hours per day of daily shopping -0.25 hours per day of assistance making appointments -2 hours per day of one staff to one resident (1:1) socialization -0.14 hours per day assistance with dressing (not section indicated: stand by to provide physical assistance as needed for dressing) -0.14 hours per day of assistance with grooming (not section: staff remind and encourage to groom daily) -0.14 hours per day assistance with bathing (prompts to bathe daily) -0.5 hours per day assistance with self-administration -0.5 hours per day verbal or visual medication reminders -0.5 hours per day of medication set ups and monitoring -0.14 hours per day of money management -5 hours per week (0.71 hours per day) managing orientation -5 hours per week (0.71 hours per day) managing anxiety -3 hours per week (0.43 hours per day) to manage repetitive behaviors -2.5 hours per week (0.36 hours per day) to manage self-injurious behaviors -2 hours per day to manage verbal aggression -2 hours per week (0.28 hours per day) managing wandering -3.5 hours per week (0.5 hours per day) managing agitation. -1 hour per day to meet other cognitive/mental health need 1: (note section: social withdrawal, depression, and isolation) -1 hour per day to meet other cognitive/mental health need 2: (note section: psychosis, paranoia, delusion, and hallucination) -1 hour per day to meet other cognitive/mental	01640		

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01640	Continued From page 11 health need 3: (note section: managing polysubstance abuse-meth-cannabis) Totaling 13.19 hours per day of individual daily services. R3's 6790 behavior plan indicated R3 required assistance with symptoms of wandering (staff set up 1:1 routines to set goals to stay focused) (facility is secured, and entry and exits are armed with alarms), managing symptoms of orientation (constant 1:1 staff engagement and redirection), anxiety (engage R3 1:1 to distract him from hyperactivity that trigger anxiety, continually engage R3 with 1:1 in structured activities to stay calm), verbal aggression (engage R3 1:1 to teach him how to communicate), self-injurious behaviors (R3 would have 1:1 staff at the house and in the community to deter R3 from engaging in at risk behaviors putting himself in harm's way), agitation, repetitive behaviors (one on one staff engagement keeps R3 at his baseline), need 1: managing depression, isolative behaviors and social withdrawal (one on one routines help R3 set goals and promote positive interaction with others), need 2: managing symptoms of psychosis, delusions, and hallucinations, need 3: managing symptoms of polysubstance abuse. R3 required staff checking on him at regular 15-30 minutes every other hour to manage R3's depression, isolative behaviors, and social withdrawal. R3's assessment dated July 1, 2026, indicated R3 was oriented to person, place, time, and situation. R3's elopement risk assessment indicated a score of not at risk for elopement and and R3 was not required to have supervision leaving. R3 required cues and reminders for dressing, grooming and bathing. R3 required assistance in the community during planned	01640		

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01640	Continued From page 12 outings. R3's service plan dated December 26, 2026, failed to include managing R3's mental health need 1: social withdrawal/depression/isolation and mental health need 2: psychosis, paranoia, delusion, hallucinations. R3 required assistance with medication administration. R3's service delivery record for August 2026, did not include daily homemaking. R3's service delivery record did not include management of R3's wandering, orientation issues, repetitive behavior, social withdrawal, depression, isolation, or polysubstance abuse. The same record indicated R3 had a safety check scheduled at 12:00 a.m., 8:00 a.m., 10:00 a.m., 12:00 p.m., 2:00 p.m., 4:00 p.m., 6:00 p.m., 8:00 p.m., and 10:00 p.m. During observation on August 28, 2026, at 8:52 a.m. was observed to exit his room and received medication from unlicensed personnel (ULP)-A. R3 was not observed to have a 1:1 staff member with him. The facility did not have any alarms at exits. The licensee inappropriately requested county payments for services R3 did not require, that included a duplicative service for medication reminders when he received assistance with medication administration and managing wandering. The licensee failed to provide daily homemaking, managing orientation issues, repetitive behaviors, polysubstance abuse and social withdrawal, depression and isolation. The licensee failed to provide 1:1 staff in the house and 1:1 staff in the community to prevent incidents related to mental health behaviors.	01640		

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01640	Continued From page 13 R4 R4 admitted to the licensee on October 21, 2021. R4's diagnoses included paranoid schizophrenia, attention-deficit hyperactive disorder, borderline intellectual functioning, cannabis dependence, cocaine abuse, delusional disorders, anxiety, depression, post-traumatic stress disorder, type II diabetes. The licensee identified R4's evacuation status as level 1: self-sufficient, ambulatory, and requiring no or minimal nursing care. R4's customized living rates worksheet (commonly known as 6790) dated January 1, 2026, was written by the licensee and submitted to CM for payment of services February 1, 2026, through January 31, 2027. The worksheet indicated the licensee would provide the following services which included the time to complete: -1 hour per day of homemaking (sweep, wash dishes, and tidying daily, vacuuming daily and as needed. R4 struggled to keep his room clean. R4 continued to smoke in his room and litters trash in his room. He eats in his room and messes up the carpet) -0.33 hours per day of shopping -0.14 hours per day of assistance making appointments -2 hours per day of one staff to one resident (1:1) socialization -0.07 hours per day of assistance with dressing (note section indicated: prompts) -0.07 hours per day of assistance with grooming (note section indicated: reminders and encouragement) -0.14 hours per day of assistance with bathing (note section indicated: constant prompts, supervision and encourage to bath daily) -0.75 hours per day to assistance with	01640		

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01640	Continued From page 14 self-administration -0.5 hours per day of verbal or visual medication reminders -0.75 hours per day of insulin injections (note section indicated: staff are required to check his blood sugars three times daily and administer his insulin via flex pens. R4 required "100%" support to manage his blood sugars) -0.28 hours per day for insulin draws (note section: RN would conduct a bi-weekly assessment of R4's blood sugars) -0.14 hours per day of money management -1 hour per day to manage orientation issues -1 hour per day to manage anxiety -1 hour per day to manage repetitive behavior -5 hours per week (0.71 hours per day) to manage self-injurious behaviors -1 hour per day to manage verbal aggression -2 hours per week (.28 hours per day) to manage property destruction -1 hour per day to meet other cognitive/mental health need 1: (note section: managing symptoms of delusions and disorganized behaviors) -1 hour per day to meet other cognitive/mental health need 2: (note section: managing schizophrenia) -1 hour per day to meet other cognitive/mental health need 3: (note section: managing symptoms of PTSD and ADHD) Totaling 19.17 hours per day for individual daily services. R4's 6790 behavior plan indicated R4 required assistance with symptoms of anxiety, property destruction, self-injurious behaviors, orientation issues (one on one staff engagement helped keep R4 at his baseline), symptoms of repetitive behaviors, need 1: delusions/hallucinations (staff plan short frequent 1:1 time with R4 throughout	01640		

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01640	Continued From page 15 the day), need 2: post-traumatic stress disorder, need 1: managing symptoms of schizophrenia (staff plan short, frequent period with R4 throughout the day). R4's assessment dated May 29, 2026, indicated R4 was oriented to person, place, time, and situation. R4's elopement risk assessment indicated a score of not at risk for elopement and had no history of elopement. R4 required cues and reminders for dressing, grooming and bathing. R4 required assistance in the community during planned outings. R4's service plan dated March 23, 2026, failed to include assistance with dressing, managing R4's mental health need 2: psychosis, paranoia, delusion, hallucinations and mental health need 3: managing symptoms of PTSD and ADHD. R4 required assistance with medication administration. R4's service delivery record for August 2026, did not include daily homemaking. R4's service delivery record did not include management of R4's orientation, anxiety, repetitive behavior, property destruction, managing R4's PTSD and ADHD symptoms, or managing schizophrenia. The licensee inappropriately requested county payments for services R4 did not require, that included a duplicative service for medication reminders when he received assistance with medication administration and daily homemaking. The licensee failed to provide management of R4's orientation, anxiety, repetitive behavior, property destruction, symptoms of PTSD, symptoms of ADHD, and symptoms schizophrenia. The licensee failed to provide 1:1 socialization and staffing for behavior	01640		

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01640	Continued From page 16 management. The licensee failed to provide daily or weekly shopping assistance. During an interview on August 28, 2026, at 10:42 a.m., R4 stated the licensee took him shopping twice a month. R4 stated he did not receive assistance with non-medical transportation. R4 stated there was one staff member at the licensee who would not cook for them. R4 stated he cleaned his own room, took out his own garbage, and did his own laundry. R4 stated he was independent with dressing, grooming, and bathing. R4 stated staff did not spend 1:1 time with him and said the licensee did not have daily activities. The licensee provided staff punch in punch out for the licensee for July and August 2026 indicated three shifts, morning, afternoon, and overnight. Staff hours worked per day equated to 24 hours. The total number of resident individual services required each day was 63 hours compared to 24 hours of staff available each day to provide services. During an observation on August 28, 2026, at 8:35 a.m., ULP-A was the only staff member working shift at the licensee. During an interview, on September 3, 2026, registered nurse (RN)-C stated the licensee determined services prior to a new resident admission by licensed assisted living director (LALD)-D, RN-E, and the licensee's case manager (CM)-F review the community support plan provided by a resident's case manager and review the customized living rate worksheet, (commonly known as the 6790). RN-C stated	01640		

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01640	Continued From page 17 assessments conducted prior to admission were dependent on where the resident was coming from. RN-C stated RN-E may interview and assess a resident for fall risk for example and ask about that during the screening process. LALD-D and CM-F submit the 6790 to the county. RN-C stated staff knew what services to provide to each resident and when based on the electronic health record which has assigned services. RN-C stated an activity calendar was posted at every house. RN-C stated daily activities were offered at the facility by the ULP who were there to work. The licensee hosted community wide gatherings, which is hosted by one of the company's houses/facilities. These gatherings include holidays, or seasonal such as a summer gathering for the residents. The licensee provided policy titled Resident Pre-Admission Assessment and Monitoring Process-Nursing, dated January 3, 2024, indicated the RN in coordination with the LALD determines whether the facility can accept a prospective resident based on resident's needs, the staffing levels, and staff qualifications and competencies. The licensee provided policy titled, Contents of Service Plan, dated January 3, 2024, indicated all residents have an up-to-date service plan identifying services to be provided based on the assessment by RN and/or other licensed health professional. Service plans would include a description of the services provided, frequency of each service according to the resident assessment and resident preferences. TIME PERIOD FOR CORRECTION: Seven (7) days.	01640		

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02360	Continued From page 18	02360		
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 four of four resident(s) reviewed (R1, R2, R3, R4) 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		