Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL394052382M
Compliance #: HL394054228C

Date Concluded: August 12, 2025

Name, Address, and County of Licensee Investigated:
Independent Group Home
2226 Irving Avenue North
Minneapolis, MN 55411
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when they failed to provide appropriate care and services necessary for the resident's medical needs including providing a renal diet and monitoring the resident's blood pressure. The facility neglected to ensure the resident attended medical appointments, including dialysis. The facility also failed to protect the resident's rights to communication with phone access and privacy with phone calls.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for maltreatment. The facility failed to provide a renal diet. The facility failed to have a system in place to ensure the staff knew when to call the nurse/medical provider regarding the resident's blood pressure readings, what constituted an abnormal blood pressure reading, and documentation of communications regarding the resident's blood pressure. Although the resident did refuse dialysis on occasion, the facility failed to provide consistent

transportation and provided no documentation of refusals. The resident required a month-long hospitalization due to missed dialysis appointments.

It was inconclusive whether the facility denied the resident's communication rights. The resident identified and was observed with a personal cell phone. Facility surveillance cameras recorded all visual and verbal interactions occurring in the common areas, but residents had privacy in their rooms. The facility did not have a statutory requirement to have a designated facility phone.

The investigator conducted interviews with facility staff members, including administrative staff, former nursing staff (at the time of the investigation the facility had not hired a new nurse), and unlicensed staff. The investigator contacted the resident's case manager and medical provider. The investigation included review of the resident record, clinic records, and related facility policy and procedures. Also, the investigator observed staff/resident interactions.

Despite repeated verbal and email requests, the facility failed to provide all requested electronic records.

The resident lived in an assisted living facility due to diagnoses that included end stage renal disease requiring dialysis and dissecting aneurism of the thoracic aorta (a bulge in a weakened area of the wall of the aorta). The resident's service plan included assistance with appointments, medication management, blood pressure monitoring, and monitoring of weights related to potential for fluid overload. The resident's assessment indicated the resident was on a regular diet but needed to eat high protein/low sodium foods.

Renal diet

Although the facility had posted documents listing foods high in potassium and low potassium, the facility menu failed to include/specify high protein/low sodium/low potassium foods available for the resident.

Documentation failed to include monitoring of food/fluid intake.

Documentation included weights taken three times per week but failed to include documentation of follow-ups by the nurse/medical provider or parameters for calling the nurse/medical provider regarding intake or weights.

During interviews, two former nurses indicated staff did not understand the renal diet, and one stated staff cooked the same food for all residents. Another former nurse stated she was not aware of the resident's diet, but believed he required "good nutrition".

Blood Pressure

Facility records lacked documentation of staff notification to a nurse or medical provider of the resident's elevated blood pressure which included readings in the 200's over 100's. (Normal blood pressure reading is 120/80.)

A facility reference document provided to staff indicated if the systolic (top number) was 180 or greater and/or if the diastolic (bottom number) was 120 or greater, the resident was in a high blood pressure urgent or emergency situation. The document contained no direction for staff.

Nursing documentation failed to indicate if or when staff provided notification of high blood pressures to a nurse.

During interviews, two former nurses stated they did not get calls from staff on the resident's blood pressures, and one former nurse stated staff did not understand blood pressure parameters or when to call the nurse.

Transportation to medical appointments/dialysis

Facility documentation of services indicated the facility provided transportation to appointments for all residents.

Documentation failed to include refusals or rationale for missed dialysis appointments.

Documentation from the dialysis facility indicated the resident received dialysis 25 times and missed dialysis 13 times in the previous three months.

Medical clinic records indicated the resident required hospitalization for a month for shortness of breath, high blood pressure, and high potassium related to missed dialysis appointments.

During an interview, the resident's medical provider stated the resident regularly attended clinic appointments and dialysis during the three years she had provided care, until he moved into the facility, when attendance became problematic and dangerous to his health.

During an interview, the resident stated he sometimes missed dialysis because the facility administration forgot to set up a ride. The resident stated his blood pressure ran high and was aware that he could have a stroke or heart attack. The resident stated he relied on the facility for transportation to appointments. The resident stated he wanted to move out and would work with his case manager.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: None identified
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
A former nurse posted documents listing high potassium foods to avoid and foods that were low potassium. Another former nurse provided education on blood pressure readings.

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
Minneapolis City Attorney
Minneapolis Police Department
Board of Executives for Long-Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39405	A. BUILDING: _____ B. WING _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENT GROUP HOME INC	2226 IRVING AVENUE NORTH MINNEAPOLIS, MN 55411

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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: #HL394054228C/#HL394052382M On June 12, 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 4 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for#HL394054228C/#HL394052382M, tag identification 0320, 2310, and 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 320 SS=G	144G.30 Subdivision 1 Regulatory powers (a) The Department of Health is the exclusive	0 320		

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0 320	Continued From page 1 state agency charged with the responsibility and duty of surveying and investigating all assisted living facilities required to be licensed under this chapter. The commissioner of health shall enforce all sections of this chapter and the rules adopted under this chapter. (b) The commissioner, upon request to the facility, must be given access to relevant information, records, incident reports, and other documents in the possession of the facility if the commissioner considers them necessary for the discharge of responsibilities. For purposes of surveys and investigations and securing information to determine compliance with licensure laws and rules, the commissioner need not present a release, waiver, or consent to the individual. The identities of residents must be kept private as defined in section 13.02, subdivision 12. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide access to current/accurate records and documentation as requested for an investigation for one of one residents (R1) reviewed for maltreatment when the licensee failed to provide requested facility documents, and posted inaccurate documents at the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	0 320		

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0 320	Continued From page 2 Findings include: The Minnesota Department of Health (MDH) investigator initiated a maltreatment investigation on June 12, 2025, at 9:45 a.m. regarding R1. Unlicensed personnel (ULP)-C stated she was the only staff in the building and did not know how to access or provide the facility schedule or contact information for staff, including other ULPs, nurses, or the assisted living director. ULP-C stated she was new and did not know where, or if there was a policy manual. ULP-C called the facility owner (O)-A. During a phone conversation on June 12, 2025, at 10:00 a.m. O-A stated he knew what the investigation was about as R1's community access for disability inclusion (CADI) waiver case manager (CM)- G and a regional ombudsman were at the facility two days prior to meet with R1. O-A stated he would not be able to come to the facility as he was "on my way to work." O-A acknowledged the MDH investigator's presence at the facility and need for documents and records. O-A requested the investigator send an e-mail with a list of requested documents. O-A stated he would have the documents forwarded via e-mail to the MDH investigator as soon as possible. During a phone conversation June 12, 2025, at 10:15 a.m. assisted living director (ALD)-B stated she also had access to the general e-mail address given to the MDH investigator. ALD-B stated she was ill and would get to sending documents "as soon as I can". The MDH investigator toured the facility, observed and photographed the following documents posted:	0 320		

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0 320	Continued From page 3 A posted document titled "Employee Schedule" (undated) identified the following: [Former Employee ULP-I] worked 6 am to 2 pm Monday through Thursday. [Former Employee ULP-J] worked 2 pm to 10 pm, Monday through Thursday, and 4 pm to 10 pm on Fridays. [Current Employee ULP-K] worked 10 pm to 6 am Monday through Thursday. [Former Employee ULP-L] worked 10 pm to 8 am Fridays, 8pm to 8 am on Saturdays, and 8pm to 6 am on Sundays. [Former Employee ULP-M] worked 8 am to 4 pm on Fridays, 8 am to 8 pm on Saturdays, and 8 am to 8 pm on Sundays. The schedule included a phone number for ALD-B, former registered nurse (RN)-F, and O-A. A posted document titled "Emergency Preparedness Plan" listed an incorrect number for the facility. (Verified on June 25, 2025, at 3:36 p.m. to belong to a private individual not affiliated with the facility.) A posted document titled "Daily Menu" listed the same selections for breakfast, lunch, dinner, and snacks for all seven days of the week. (See tag 2310 for details) A posted document titled "Weekly Staff Schedule" indicated two (unnamed) staff scheduled for morning shift (7:00 a.m. to 3:00 p.m.), two (unnamed) staff scheduled for afternoon shift (3:00 p.m. to 11:00 p.m.), and one (unnamed) staff on night shift (11:00 p.m. to 7:00 a.m.). The notes section of the document indicated "We ensure at least two staff members are present during morning and afternoon shifts for safety and support. The notes also indicated "We have a designated on-call staff (e.g. staff 7) for	0 320		

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0 320	Continued From page 4 emergencies or unexpected absences." On June 12, 2025, at 1:24 p.m. the MDH investigator sent a message requesting the following documents to the email provided (INDEPENDENTGRPHOME@GMAIL.COM).\ 1) Staff names and contact phone numbers 2) VA/Maltreatment prevention policy 3) Transportation of clients policy 4) Resident rights policy 5) Resident rules 6) Service plan policy 7) Documentation policy 8) Incident reports dated 3/1/25 through 6/12/25 9) Hospitalizations dated 3/1/25 through 6/12/25 10) R1's records: Documentation of services completed 5/1/25 through 6/12/25, medication administration record (MAR) May 2025, MAR June 2025, treatment administration record (TAR) May 2025, TAR June 2025, Weights dated 3/1/25 through 6/12/25, Blood Pressure Order, Diet order, Blood pressure readings dated 3/1/25 through 6/12/25. An e-mail received on June 16, 2025, at 10:56 a.m. from ALD-B read "Yes, we should be sending this requested info asap. I was under the weather last week as I explained to you otp [sic] and just got back to work." An e-mail received on June 19, 2025, at 9:49 p.m. included names and phone numbers of ALD-B, Owner-A, current registered nurse-N, unlicensed personnel (ULP)-C, and ULP-K. ALD-B indicated this was the current list of staff who worked at the facility. The email failed to include the remaining requested documents. An e-mail sent by the MDH investigator on June 23, 2025, at 7:46 a.m. requested the following	0 320		

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0 320	Continued From page 5 documents not yet received: 1) Transportation of clients policy 2) Resident rules 3) Incident reports dated 3/1/25 through 6/12/25- for all residents 4) Hospitalizations dated 3/1/25 through 6/12/25-for all residents 5) R1 records: Documentation of services completed 5/1/25 through 6/12/25, MAR May 2025, MAR June 2025, TAR May 2025, TAR June 2025, Blood Pressure Order, Diet order. An e-mail received on June 23, 2025, at 10:00 a.m. written by ALD-B read: "Will look into this and send them to you promptly." During an interview on June 24,2025, at 9:00 a.m. ALD-B stated she was unable to get documents out because "the RN is on vacation, and I rely on him". ALD-B then stated she was referencing registered nurse (RN)-H, who was "not an employee, but works when we need him." The MDH investigator informed ALD-B that she had the list of documents since June 12, 2025, and requested she send them today. The MDH investigator interviewed RN-H on June 24, 2025, at 2:00 p.m. and verified that he was an employee of the facility. An e-mail sent on June 24, 2025, at 2:03 p.m. to ALD-B included a request for additional documents based on the interview completed with ALD-B that morning to include the following: 1) R1's Current Service Plan 2) Copy of the "graph" that HHAs use to determine if a blood pressure is out of range, 3) Current menu 4) R1's progress notes dated 5/5/25 through 6/12/2025 for both nursing and home health	0 320		

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0 320	Continued From page 6 aides. Review of Netstudy on June 25, 2025, at 4:00 p.m., showed that RN-H was affiliated with the facility and had a background study clearance dated April 18, 2025. An e-mail received on June 24, 2025, at 10:00 p.m. from ALD-B indicated "I will be sending the requested info as soon as I gather them since I am also relying on the old RN who is not accessible at the moment." An e-mail received June 26, 2025, at 12:01 p.m. from ALD-B failed to include the following: 1) Resident rules 2) Updated UDALSA 3) Incident reports dated 3/1/25 through 6/12/25- for all residents 4) Hospitalizations dated 3/1/25 through 6/12/25-for all residents 5) R1 records: Documentation of services completed 5/1/25 through 5/31/25, Blood Pressure Order with parameters for contacting a nurse or provider, Diet order. 6) R1's Current Service Plan 7) Names and contact information for all employees. As of July 22, 2025, at 5:00 p.m. ALD-B had not provided the following: 1) Resident rules 2) Updated UDALSA 3) Incident reports dated 3/1/25 through 6/12/25- for all residents 4) Hospitalizations dated 3/1/25 through 6/12/25-for all residents 5) R1 records: Documentation of services completed 5/1/25 through 5/31/25, Blood Pressure Order, Diet order.	0 320		

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0 320	Continued From page 7 6) R1's Current Service Plan 7) Names and contact information for all employees. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 320		
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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide appropriate care and services based on the needs of the resident and according to an up-to-date service plan subject to accepted health care standards for of one of one residents (R1) when they failed to provide R1 a renal diet, failed to ensure transportation to dialysis and medical appointments, and failed to monitor R1's blood pressure. This resulted in harm to R1 who required hospitalization. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	02310		

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02310	Continued From page 8 Findings include: R1 admitted to the facility October 24, 2024, due to diagnoses that included end stage kidney disease stage 5 (kidney failure) requiring dialysis three times weekly, high blood pressure, and aortic dissection. R1's care plan dated March 17, 2025, indicated R1 was independent with bathing, dressing, hygiene, mobility, transfers, toileting, activities, and finances. R1's care plan indicated R1 received a regular diet, required meal set up, received staff monitoring of weights, reminded staff to ensure he ate a low-potassium/high protein diet, and received daily blood pressure readings. Renal diet R1's nursing assessment dated November 1, 2024, indicated R1 received a regular diet, required some help with meal set-up, and "needs to eat high protein foods." The assessment indicated staff were to ensure adherence to a low-potassium, high-protein diet to manage kidney failure. R1's nursing assessment dated March 17, 2025, indicated R1 received a regular diet. The assessment indicated R1 required high protein foods due to end stage kidney failure and required a low sodium diet due to high blood pressure. R1's care plan dated March 17, 2025, indicated R1 received a regular diet and noted R1 needed to eat high protein foods, a low sodium diet, and reminders to limit fluids.	02310		

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02310	Continued From page 9 R1's nursing progress notes dated April 10 and 19, 2025, indicated R1 maintained adequate hydration and nutrition. Neither progress note indicated amounts or contents of R1's intake. R1's unlicensed personnel (ULP) progress note dated April 22, 2025, at 5:25 p.m. indicated R1 ate breakfast and lunch. The note did not indicate amounts or contents of R1's intake. R1's ULP progress note dated April 25, 2025, at 9:04 p.m. indicated R1 ate "meal and snack". The note did not indicate amounts or contents of R1's intake. R1's ULP progress note dated April 26, 2025, at 6:28 p.m. indicated R1 "didn't take any food" the whole day. R1's ULP progress note dated April 27, 2025, at 7:30 a.m. indicated R1 "ate food". The note did not indicate amounts or contents of R1's intake. R1's ULP progress note dated April 27, 2025, at 7:46 p.m. indicated R1 ate "meal and snack". The note did not indicate amounts or contents of R1's intake. R1's nursing progress note dated April 28, 2025, at 11:09 a.m. indicated R1 maintained adequate hydration and nutrition. The note did not indicate amounts or contents of R1's intake. R1's ULP progress note dated May 1, 2025, at 9:16 p.m. indicated R1 ate breakfast, lunch, and dinner. The note did not indicate amounts or contents of R1's intake. R1's ULP progress note dated May 3, 2025, at 7:53 p.m. indicated R1 ate breakfast. The note	02310		

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INDEPENDENT GROUP HOME INC	2226 IRVING AVENUE NORTH MINNEAPOLIS, MN 55411

(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 10 did not indicate amounts or contents of R1's intake. R1's nursing progress note dated May 3, 2025, at 8:19 p.m. indicated R1 maintained adequate hydration and nutrition. The note did not indicate amounts or contents of R1's intake. R1's ULP progress note dated May 4, 2025, at 5:18 p.m. indicated R1 ate breakfast, lunch, and dinner. The note did not indicate amounts or contents of R1's intake. R1's Hennepin Healthcare Coordinated Care Center office visit note dated May 23, 2025, indicated R1 was "not eating right, not provided with appropriate meals that follow low sodium and renal diet that are advised." The note indicated R1 had 1+ pitting edema in both right and left lower legs. The note identified abnormal lab results including elevated glucose, BUN (blood urea nitrogen), creatinine, total protein, prothrombin, and INR (international normalized ratio which measures blood clotting time). Labs indicated low red blood cell count, low hemoglobin, and low hematocrit. R1's nursing progress note dated May 24, 2025, at 10:29 a.m. indicated R1 "maintained adequate hydration and nutrition". The note did not indicate amounts or contents of R1's intake. R1's nursing progress note dated June 6, 2025, at 7:36 p.m. indicated "per dialysis nurse [R1's] potassium is elevated" and registered nurse (RN)-H contacted the facility "food manager" (unnamed person) who told him the resident was on a renal diet with lower potassium and low sodium.	02310		

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02310	Continued From page 11 R1's nursing progress note dated June 8, 2025, at 5:04 p.m. indicated RN-H educated staff and R1 about a renal diet, gave resources about food to eat and food to avoid. R1's nursing progress note dated June 10, 2025, at 10:20 p.m. indicated R1's food intake was "good, as per staff". The note did not indicate amounts or contents of R1's intake. On June 12, 2025, at 10:06 a.m. the Minnesota Department of Health (MDH) investigator observed and photographed the facility daily menu (undated) which indicated the following for all seven days of the week: Breakfast: omelet with bread, cereal with milk, boiled eggs with bread, nutrition bar, or client's choice. Lunch: chicken sandwich, cheeseburger, taco, supreme pizza, grill(sic) cheese, tuna sandwich, or client's choice. Dinner: rice with chicken, pasta with ground beef, speggeti (sic) with meatball, or client's choice. Snack: fresh apple, orange, chips, bananna (sic), nutrition bar. On June 12, 2025, at 10:26 a.m. Minnesota Department of Health (MDH) investigator observed and photographed two documents taped to the wall in the kitchen. One document titled "Avoid these food" and had pictures/names of the following: avocado, banana, potatoes, spinach, beans, citrus juices, and fish. The other document titled "Low Potassium Food Guide" listed foods to eat and foods to avoid including whole wheat bread, milk, cheese, oatmeal, tuna, brown rice, tomato sauce, tomatoes, bananas, granola, granola bars, nuts, sweet potatoes, trail mix, spinach, brussels sprouts, ham, and chips.	02310		

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02310	Continued From page 12 During an interview on June 24, 2025, at 9:00 a.m. assisted living director (ALD)-B stated a dietician drafted the facility menu. ALD-B stated she knew a renal diet consisted of avoiding foods high in potassium and salt but was not sure about protein. During an interview on June 24, 2025, at 2:00 p.m. registered nurse (RN)-H stated he provided the two documents taped to the wall which identified foods high in potassium and foods low in potassium for the staff to reference. RN-H stated although he provided education, staff did not understand the renal diet. The Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated July 19, 2022, indicated services available at the facility did not include providing a renal diet. The MDH investigator requested but did not receive an updated UDALSA. An e-mail received from ALD-B on June 24, 2025, at 9:46 p.m. included an undated document titled "Independent Group Home: Food Menu for a week 6/22/25-6/28/25." The menu included the following foods: Eggs with spinach, whole grain toast, orange slices, whole grain roll, mixed greens salad, broccoli, brown rice, Greek yogurt, almonds, avocado, fruit salad (unknown ingredients), whole grain bread, whole grain waffles, milk, whole grain pita bread, sweet potatoes, peanut butter, trail mix, spinach, whole grain crackers, tomatoes, brussels sprouts, granola, and ham. The menu provided no alternative selections. Review of website The Best Foods for Kidney Health on June 24, 2025, at 9:42 a.m.	02310		

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02310	Continued From page 13 (https://health.clevelandclinic.org/renal-diet) indicated a renal diet was designed to cut out sodium, phosphorus, and potassium. The website indicated a renal diet became increasingly more restrictive as kidney function declined, starting with limiting salt and protein. The website indicated a full renal diet was designed for people with advanced or end-stage kidney disease who needed dialysis included vegetables, fruit, and protein in smaller doses. The website indicated stage four (and higher) kidney disease required foods lower in phosphorus and recommended avoiding the following potassium rich foods: cantaloupe, honeydew melon, bananas, oranges, orange juice, avocado, prune juice, tomatoes, tomato sauce, tomato juice, dried beans, pumpkin, winter squash, cooked greens, spinach, kale, collards, Swiss chard, broccoli, brussels sprouts, nuts, nut butters, bran cereals, granola, salt, salt substitutes, and molasses. Review of website: Chronic kidney disease: What to know about this common, serious condition - Harvard Health on June 24, 2025, at 1:21 p.m. (https://www.health.harvard.edu/diseases-and-conditions/chronic-kidney-disease-what-to-know-about-this-common-serious-condition) indicated steps to eating right for kidney disease included reducing sodium intake, limiting protein intake, limiting potassium (such as bananas, oranges, and potatoes), and limiting phosphorus (meat, poultry, fish, dairy products, and nuts). Transportation to dialysis and medical appointments R1's assessment dated November 1, 2024, indicated R1 required transportation to appointments and shopping. R1's Hennepin Healthcare Coordinated Care	02310		

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02310	Continued From page 14 Center record dated January 27, 2025, indicated appointment priority was to get R1 to dialysis. The note indicated nurse practitioner (NP)- E met with R1 to determine barriers in getting R1 to dialysis consistently three times per week as well as scheduled appointments. The note indicated R1 also missed an appointment with psychiatry and for a liver health assessment (fibro scan). The note indicated R1 was hospitalized for shortness of breath and high potassium due to missed dialysis. Medical records received from Davita Dialysis indicated for the dates of March 17, 2025, through June 11, 2025, R1 received dialysis 25 times (March 17, 21, 24, 26, 28, and 31, 2025; April 2, 5, 8, 11, 16, 18, 21, and 28, 2025; May 2, 6, 10, 12, 16, 21, and 23, 2025; June 2, 7, 9, and 11, 2025.) The records indicated R1 missed dialysis 13 times from March 17, 2025, through June 11, 2025. (March 19, 2025; April 9, 14, 23, 25, and 30, 2025; May 7, 14, 19, 26, 28, and 30, 2025; June 4, 2025) During an interview on June 12, 2025, at 10:45 a.m. unlicensed personnel (ULP)-C stated R1 required very little assistance apart from administration of medications and transportation to dialysis and medical appointments. ULP-C stated R1 never refused medications, meals, snacks, or dialysis. During an interview on June 12, 2025, at 11:00 a.m. R1 stated assisted living director (ALD)-B, set up transportation to clinic appointments and dialysis. R1 stated sometimes he did not get to dialysis because the facility "forgot". R1 stated he wanted to move to a place out of the city, to a quiet suburb where he could have a garden. R1 stated he preferred to see the nurse practitioner	02310		

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02310	Continued From page 15 at the Coordinated Care Center clinic. During an interview on June 18, 2025, at 10:00 a.m. nurse practitioner (NP)-E stated R1 came to the Hennepin Health Care Coordinated Care Clinic as he was a high utilizer of the emergency room. NP-E stated R1 had been a patient of the clinic since September 2022. NP-E stated R1 attended his appointments and had a positive relationship with the clinic until he moved to this facility October 2024, when visits stopped. NP-E stated R1 had high blood pressure that required monitoring as he had an aortic dissection. NP-E stated she made multiple efforts to arrange transportation for R1 to the clinic, but the facility did not support his appointments. NP-E stated ALD-B told her that R1 was independent, and she could not make him do anything. NP-E stated R1 had only been back to the clinic once in the last month, which was inadequate to monitor his multiple medical conditions. NP-E stated R1 required hospitalization from February 17, 2025, through March 15, 2025. NP-E stated R1 told her he wanted to continue at the clinic and stated he wanted to move from the facility. NP-E stated the facility then changed his primary clinic and would not allow communication. NP-E stated she felt the facility administration was obstructing R1's care. The MDH investigator requested but did not receive hospitalization records from North Memorial Medical Center for the above noted dates. During an interview on June 24, 2025, at 9:00 a.m. ALD-B stated regarding R1's transportation to dialysis, "we always have it set up for a ride with Blue and White taxi." ALD-B then stated she had begun working with Blue and White taxi "in March of 2025." ALD-B stated when R1 missed a	02310		

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02310	Continued From page 16 dialysis appointment, "we just bring him the next day". ALD-B stated all refusals were "documented in the RN's notes." Review of R1's nursing progress notes dated March 1, 2025, through June 24, 2025, indicated RN-H documented on June 6, 2025, at 7:36 p.m. R1 refused dialysis on June 4, 2025, and June 6, 2025. The progress note further indicated "[R1] continues dialysis three times a week." There were no other nursing progress notes during the time reviewed that indicated R1 refused to go to dialysis. The transportation policy dated January 1, 2024, indicated scheduled medical transportation was provided for non-emergency medical trips (doctor visits, therapy, lab work) and coordination with healthcare providers as needed. The policy indicated drivers must have valid driver's license, pass background checks, and receive training in safe transfer techniques. The policy indicated there would be no extra fee for medical trips. Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated July 19, 2022, indicated services available at the facility did include assistance with arranging transportation to medical and social service appointments as required. The MDH investigator requested but did not receive an updated UDALSA. Blood Pressure monitoring R1's master care plan dated March 17, 2025, indicated staff were to check R1's blood pressure daily. The care plan indicated staff were to monitor R1's blood pressure according to the schedule and notify the nurse if blood pressure	02310		

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02310	Continued From page 17 readings were "abnormal" but provided no parameters. The MDH investigator requested but did not receive documentation of orders for blood pressures and/or parameters for when to contact a nurse. R1's facility medical record blood pressure readings included the following: April 24, 2025 - 188/100 April 27, 2025 - 223/106 May 5, 2025 - 233/107 May 6, 2025, am - 222/103 May 6, 2025, bedtime - 233/103 May 9, 2025 - 219/99 May 12, 2025 - 185/89 May 24, 2025 - 184/170 May 25, 2025, am - 204/92 May 25, 2025, pm - 197/92 May 26, 2025 - 207/98 May 28, 2025 - 216/81 June 2, 2025, am - 186/88 June 2, 2025, pm - 183/81 June 2, 2025, bedtime - 183/81 June 3, 2025, am - 188/75 June 3, 2025, pm - 191/75 June 3, 2025, bedtime - 207/75 June 4, 2025, bedtime - 262/140 June 8, 2025, am - 202/103 June 8, 2025, pm - 185/86 June 8, 2025, bedtime - 185/86 June 9, 2025 - 191/108 June 11, 2025, am - 189/103 June 11, 2025, bedtime - 201/100 June 12, 2025 - 189/100 R1's nursing progress note dated March 17, 2025, ay 9:12 a.m. indicated R1's blood pressure reading was 150/90 with no complaints of chest	02310		

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02310	Continued From page 18 pain or other acute symptoms. The progress noted indicated R1's vital signs were "being closely monitored" and R1 received "frequent blood pressure checks." The note did not indicate if staff contacted the nurse regarding R1's blood pressure readings or if the nurse contacted R1's provider. R1's weekly nursing progress note dated April 10, 2025, at 1:27 p.m. indicated R1's blood pressure was 165/98. The note indicated R1 denied pain and blood pressure was "Still elevated". The note did not indicate if staff contacted the nurse regarding R1's blood pressure readings or if the nurse contacted R1's provider. R1's weekly nursing progress note dated April 19, 2025, at 9:54 p.m. indicated R1's blood pressure was 167/98. The note indicated R1 denied pain. The note did not indicate if staff contacted the nurse regarding R1's blood pressure readings or if the nurse contacted R1's provider. R1's weekly nursing progress note dated April 28, 2025, at 11:09 a.m. indicated R1's blood pressure was 144/78. The note indicated R1 denied pain. The note did not indicate if staff contacted the nurse regarding R1's blood pressure readings or if the nurse contacted R1's provider. R1's weekly nursing progress note dated May 3, 2025, at 8:19 a.m. indicated R1's blood pressure was 167/78. The note indicated R1 denied pain. The note did not indicate if staff contacted the nurse regarding R1's blood pressure readings or if the nurse contacted R1's provider. R1's weekly nursing progress note dated May 13, 2025, at 4:54 p.m. indicated R1's blood pressure was 163/68. The note indicated R1 denied pain.	02310		

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02310	Continued From page 19 The note did not indicate if staff contacted the nurse regarding R1's blood pressure readings or if the nurse contacted R1's provider. R1's Hennepin Healthcare Coordinated Care Center office visit note dated May 23, 2025, indicated R1 had a dissecting aneurysm of the thoracic aorta (a tear in the inner layer of the main artery) related to high blood pressure that could result in death due to severe internal bleeding. R1's weekly nursing progress note dated May 24, 2025, at 10:29 a.m. indicated R1's blood pressure was 171/68. The note indicated R1 denied pain. The note did not indicate if staff contacted the nurse regarding R1's blood pressure readings or if the nurse contacted R1's provider. R1's weekly nursing progress note dated June 6, 2025, at 7:36 p.m. indicated R1's "blood pressure has been significantly elevated past couple of days but [R1] asymptomatic." The note did not indicate if staff contacted the nurse regarding R1's blood pressure readings or if the nurse contacted R1's provider. R1's nursing progress note dated June 10, 2025, at 10:20 p.m. indicated RN-N met with R1 to introduce herself as the new RN and completed a "general basic nursing assessment." The note indicated "vital signs stable." The note did not indicate if staff contacted the nurse regarding R1's blood pressure readings or if the nurse contacted R1's provider. During an interview on June 24, 2025, at 10:00 a.m. assisted living director (ALD)-B stated the unlicensed staff were trained to "check the chart" if R1's blood pressure was high, call "someone	02310		

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02310	Continued From page 20 who knew more, medically" or the nurse, and call 911. ALD-B stated staff were trained to recheck a high blood pressure three times and if not coming down to call 911. ALD-B stated high systolic blood pressure would be anything over 180. During an interview on June 23, 2025, at 9:16 a.m. former RN-F stated she believed staff called her with R1's high blood pressure readings, but did not document any calls. RN-F stated she went to the facility once per week, but only worked with R1 two or three times as she worked at the facility for only two months. During an interview on June 24, 2025, at 2:00 p.m. former RN-H stated staff were prompted in the electronic health record (R-Task) to notify the nurse if R1's systolic blood pressure reading was over 180. RN-H stated he only worked at the facility temporarily for 6 weeks to help them out after RN-F left. RN-H stated staff did not know what was considered a high blood pressure, or to call the nurse. During an interview on June 26, 2025, at 1:12 p.m. former RN-N stated staff were not trained in orientation about blood pressures, but as a nurse she did assessments and educated staff to call her if R1's blood pressure was high (anything over 129 systolic). RN-N stated she worked at the facility for two weeks and put in her notice June 25, 2025. A facility document ("the chart" emailed by ALD-B on June 24, 2025, at 2:05 p.m.) indicated the following information about blood pressure readings: < (less than)120 [systolic (top number)] and < 80 [diastolic (bottom number)] = normal blood pressure	02310		

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02310	Continued From page 21 120-129 and < 80 - elevated blood pressure 130-139 or 80-89 - stage 1 hypertension 140+ or 90+ - Stage 2 hypertension 180+ and/or 120+ - Hypertensive urgency or emergency. The document contained no direction for staff. The MDH investigator requested but did not receive incident reports dated March 1, 2025, through June 12, 2025. The MDH investigator requested but did not receive documentation of services provided to R1 for the dates of May 1, 2025, through May 31, 2025. The Service Plan policy dated August 1, 2024, indicated the facility would provide all services required by the current service plan. The clinical records policy dated August 1, 2024, indicated a resident record would contain pertinent health information, documentation of incidents and significant changes in the resident's status with actions taken in response to the needs of the resident. The policy indicated the resident record would contain documentation of services provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	02310		
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.	02360		

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02360	Continued From page 22 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		