

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL343601721M  
**Compliance #:** HL343606684C

**Date Concluded:** April 30, 2026

**Name, Address, and County of Licensee**

**Investigated:**

Capital Home Health Care LLC  
3516 73<sup>rd</sup> Avenue  
Brooklyn Park, MN, 55429  
Hennepin County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Kris Detsch, RN  
Special Investigator

**Finding:** Not Substantiated

**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 a resident when they failed to provide supervision. As a result, the resident broke the window in his room and cut his hand. The resident then started a fire in his room.

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was not substantiated. The incident was a sudden and unforeseen event. At the time of the incident an unlicensed personnel (ULP) was helping the resident with his "virtual" (video) medical appointment with a mental health physician. During the visit, the resident became angry, broke his window, and cut his hand. Law enforcement arrived at the facility and tried to get him medical care, but he continued to be aggressive and fought with them. The resident took a gas "torch" he had hidden in his room and started a fire, causing an evacuation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator went to the facility and observed it was uninhabitable due to fire damage.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia (delusions and hallucinations). The resident's service plan included assistance with medications, meals, and behavior management. The resident's care plan indicated he walked independently.

During an interview, the ULP said he met the resident at the time he admitted into the facility and said the resident was "calm", but his mental state deteriorated. The ULP said the resident talked about "Satan" and he became increasingly aggressive. On the day of the incident, the ULP said the resident's behavior was "deteriorating bad." He walked around in circles in his room and cussed. The ULP said the facility made a medical appointment (virtually) with the resident's mental health physician because of these behaviors. The ULP said he set up the virtual visit and started to talk with the physician. The physician then asked to talk with the resident. The ULP attempted to get the resident to talk with the physician, however the resident became aggressive. The resident punched the window, then clenched his fist and ran toward the ULP. The ULP ran out of the facility for his own safety. The ULP said during this time, the physician told him to call the police. The ULP said he did not see how the fire started; however multiple law enforcement officers were at the facility when it occurred.

During an interview, a manager said he also went to the facility at the time of the incident and the resident "lunged" at him with a shard of glass. The manager said the resident did not cooperate with law enforcement. Law enforcement used "pepper balls" to get him out of his room. The manager said during this time, the resident got a "propane tank" and lit his room on fire. The manager said the facility was unaware the resident had a propane tank because he hid it in his closet. The manager said law enforcement took the resident to the hospital. The manager said the facility evacuated the other residents and they were unharmed from this incident.

Law enforcement records indicated multiple officers tried to get the resident out of his room for treatment for wounded hand. The records indicated the resident was aggressive and did not comply with their instructions. The resident used a small propane torch to start the fire in his bedroom. Law enforcement found street drug paraphernalia with the resident when they apprehended him.

During an interview, a family member said the resident went to the hospital for medical treatment due to smoke inhalation but then transferred to a mental health unit.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

**“Not Substantiated” means:**

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

**Neglect: Minnesota Statutes, section 626.5572, subdivision 17**

“Neglect” means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

- (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
- (2) which is not the result of an accident or therapeutic conduct.

**Vulnerable Adult interviewed:** No. Unable.

**Family/Responsible Party interviewed:** Yes.

**Alleged Perpetrator interviewed:** Not Applicable.

**Action taken by facility:**

No action taken.

**Action taken by the Minnesota Department of Health:**

No further action taken at this time.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34360</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/31/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CAPITAL HOME HEALTH CARE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3516 73RD AVENUE BROOKLYN CENTER, MN 55429</b>
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0 000	<p><b>Initial Comments</b></p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>HL343601942C/HL343608782M HL343606684C/HL343601721M HL343606674C</p> <p>On March 31, 2026 , the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were four residents receiving services under the provider's Assisted Living license.</p> <p>The following correction orders are issued for HL343601942C/HL343608782M, tag identification 1620, 2360. No correction orders are issued for HL343606684C/HL343601721M. No correction orders are issued for HL343606674C.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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01620	Continued From page 1	01620		
01620 SS=J	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.</p> <p>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.</p> <p>(c) Resident reassessment and monitoring must be conducted by a registered nurse:</p> <p>(1) no more than 14 calendar days after initiation of services;</p> <p>(2) as needed based on changes in the resident's needs; and</p> <p>(3) at least every 90 calendar days.</p> <p>(d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment.</p> <p>(e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be</p>	01620		

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01620	<p>Continued From page 2</p> <p>completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.</p> <p>(f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct change of condition nursing assessments to address drug seeking behavior and street drug overdoses for one of one resident (R1) with records reviewed. Because of this failure, the licensee did not implement further services to identify and mitigate the risks of R1's behavior. R1 died from a drug overdose (fentanyl, and methamphetamine).</p> <p>This practice resulted in a level four violation (a violation that harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1's discharge orders from a state operated treatment program dated November 6, 2024, indicated R1 was on a commitment order as the result of several criminal charges that led to a</p>	01620		
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01620	<p>Continued From page 3</p> <p>Rule 20 determination (time served can be done in a mental health treatment facility) and found incompetent. Conditions of discharge required R1 to take his medications as prescribed, maintain safety and well being, abstain from alcohol, illegal drugs and medications not prescribed to him. Violation of the terms requires a more restrictive settings and not in agreement with treatment or if there was a concern about R1's safety due to mental illness and/or consequences of substance abuse. The provisional discharge may be extended by the court.</p> <p>Court records dated March 4, 2025, indicated after a six month review, a law judge determined to continued R1's commitment order with an expiration date of August 25, 2025.</p> <p>R1 admitted into the licensee on June 16, 2025, for diagnoses including opioid dependence, major depressive disorder, and generalized anxiety disorder.</p> <p>R1's service plan dated June 17, 2025, (addendum to Contract) indicated R1 required behavior management for agitation, socialization, anxiety, orientation, psychosis, wandering, aggression, property destruction, repetitive behaviors, and verbal aggression. The service plan indicated the frequency for these services was two to three times per day. The service plan lacked indication or specification of services to manage drug seeking behavior and/or street drug use.</p> <p>No further service plan addendums provided.</p> <p>R1's admission nursing assessment dated June 17, 2025, indicated R1 admitted from an intensive residential treatment services (IRTS) facility. The</p>	01620		
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01620	<p>Continued From page 4</p> <p>nursing assessment indicated R1's history included opioid-induced psychotic disorder with hallucinations, psychoactive substance abuse, and generalized anxiety disorder. The assessment indicated R1 did not have a history of elopement attempts, however, the assessment also indicated R1 had a history of elopement and leaving the property. Interventions to manage elopement included for staff to remind him to let them know when he was leaving, remind him to charge his cellphone, and make sure windows are secured to provide a safe environment, but do not disturb him when he was listening to music. The assessment indicated R1 used "street drugs" and had overdosed with unknown drugs and required hospitalization. Interventions to manage his drug use included safety checks. The assessment failed to identify the frequency of safety checks. Although the assessment indicated registered nurse (RN)-D completed the assessment in person, the assessment also included RN-D's handwritten signature with the electronic date of April 9, 2026.</p> <p>Court records dated August 21, 2025, indicated a law judge determined R1 was a chemically dependent person. The record indicated R1 was "likely to attempt to physically harm himself or others" and risk for self neglect with failing to provide himself with food, clothing, shelter and medical care. The court extended the terms of his commitment until August 21, 2026.</p> <p>Incident report dated September 5, 2025, at 4:42 a.m., indicated staff members found R1 unconscious in his bedroom and called emergency services (911). The report indicated R1 did not have a pulse and required cardiopulmonary resuscitation (CPR). R1 required Narcan (medication used to reverse</p>	01620		
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01620	<p>Continued From page 5</p> <p>opioid overdose). R1 was hospitalized.</p> <p>Law enforcement records dated September 5, 2025, indicated R1 was in his downstairs bedroom when law enforcement arrived. R1 was unconscious and required CPR. Licensee staff told law enforcement they gave R1 two shots of Narcan, but they were unsure they did it correctly. Law enforcement found substances consistent with street drugs and drug paraphernalia in R1's room. Additional records indicated the substances were fentanyl, methamphetamine, marijuana, and olanzapine (anti-psychotic drug).</p> <p>Hospital records dated September 5, 2025, indicated R1 had a fentanyl overdose and acute (sudden) hypoxic respiratory failure (low oxygen levels). R1 also had lung injury/pneumonia, and pulmonary edema (fluid in lungs). Hospital records indicated R1's medical diagnoses included schizophrenia, bipolar disorder, polysubstance use disorder, and multiple incidences of drug overdoses from fentanyl. The records indicated R1 left the hospital against medical advice and returned to the licensee.</p> <p>R1's record lacked a nursing assessment following his hospitalization and drug overdose.</p> <p>Law enforcement records dated September 18, 2025, indicated the licensee contacted law enforcement because they found a baggie of white substance in R1's room. Law enforcement went to the facility and licensed assisted living director (LALD)-A told them he completed "periodic room checks" and found the substance in R1's room. LALD-A told law enforcement R1 had a prior drug overdose. The records indicated R1 told them the substance was from another individual who visited with him previously in the</p>	01620		

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01620	<p>Continued From page 6</p> <p>day. LALD-Atold officers whenever R1 was with this individual, he came back "high." Law enforcement records indicated they determined the substance was a substantial amount (two grams) of fentanyl.</p> <p>Nursing assessment dated September 25, 2025, indicated RN-D completed a routine (required) 90-day nursing assessment. The assessment contained a section titled, "Summary" which indicated R1 had an emergency room visit due to a drug overdose. The summary indicated physician's prescribed Narcan. The assessment indicated RN-D made no further changes to R1's elopement, or drug use interventions. This assessment failed to identify diagnoses as indicated in the hospital records. This assessment failed to identify R1 had a court appointed commitment. The nursing assessment failed to include updated, person centered, individualized interventions to address R1's increasing drug seeking behavior and elopements.</p> <p>Incident report dated October 28, 2025, indicated R1 eloped. The report indicated R1 got into someone's car, and they drove off. The incident report indicated unlicensed personnel (ULP)-B told M-A about the elopement. The incident report lacked further details about R1's elopement length or when he returned.</p> <p>Incident report dated November 15, 2025, at 1:50 a.m., indicated LALD-A called an ambulance because R1 had chest pain. The report lacked further information regarding what occurred.</p> <p>R1's record lacked a nursing assessment following R1's elopement and for reported chest pain needing medical response.</p>	01620		
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01620	<p>Continued From page 7</p> <p>Incident report dated December 14, 2025, at 8:10 a.m., indicated facility staff found R1 in his bedroom. R1 did not have a pulse and staff initiated CPR. The report indicated emergency responders determined R1 was deceased.</p> <p>Law enforcement records dated December 14, 2025, indicated R1 was in his downstairs basement bedroom when they arrived. The records indicated R1's body was in rigor mortis (body stiffening usually around six to twelve hours after death). Law enforcement found a burnt tinfoil with white substance and other drug paraphernalia on R1's bed.</p> <p>On April 9, 2026, at 10:31 a.m., case manager (CM)-F said R1 had an extensive history of drug use (including fentanyl) and multiple interactions with law enforcement for criminal acts, mostly drug related. CM-F said the court system determined R1 required a "commitment" (mandatory treatment). CM-F said when R1 was ready to discharge from the IRTS facility, she met with leadership from the assisted living facility to discuss his needs. CM-F said she gave the facility leadership R1's court documents, hospital records, and IRTS records. CM-F said the facility accepted him for admission. After admission, R1 overdosed on drugs, so she met with facility leadership again to discuss his needs. CM-F said they discussed R1 needed closer supervision. CM-F said facility staff also found drugs (fentanyl) in R1's room.</p> <p>On April 9, 2026, at 12:04 p.m., ULP-B said R1's behavior escalated about one month after admission. R1 frequently eloped out of a window in the basement and "ran away." ULP-B said he thought R1 got substances (drugs) from</p>	01620		

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01620	<p>Continued From page 8</p> <p>individuals who lived across the street, so he went over to the facility across the street and spoke to their staff about it. ULP-B said he completed hourly safety checks after R1's initial drug overdose at the facility. ULP-B said he told RN-D about R1's behaviors and received verbal instructions to "watch" him and to call 911 if needed.</p> <p>On April 14, 2026, at 10:53 a.m., RN-D said she completed R1's nursing admission assessment on June 17, 2025, his required 14 day assessment on July 1, 2025, and his 90-day assessment on September 25, 2025. RN-D said she did not complete any additional nursing assessments prior to R1's death.</p> <p>The licensee's policy titled, Initial and On-going Nursing Assessment of Resident's Under the Comprehensive Licensed Agency, no date, indicated the licensee registered nurse would complete comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required including change of condition.</p> <p>TIME PERIOD FOR CORRECTION: SEVEN (7) DAYS.</p>	01620		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p> <p>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.</p>	02360		

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02360	<p>Continued From page 9</p> <p>Findings include:</p> <p>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.</p>	02360		