Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL350832521M
Compliance #: HL350839082C

Date Concluded: May 21, 2026

Name, Address, and County of Licensee Investigated:
Chase Courageous Group Home
7708 Regent Ave North
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lacey Eggersdorfer, 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 alleged perpetrator (AP), an unlicensed staff personnel, physically abused the resident when the AP hit the resident during a physical altercation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. There was no evidence to support the unlicensed staff personnel abused the resident. At the time of the incident, police were contacted, and the resident was charged with assault.

The investigator conducted interviews with facility staff members, including unlicensed staff and administrative 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.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia, anxiety, and post-traumatic stress disorder. The resident's service plan included assistance with medications, and redirection and reassurance with behaviors. The resident's assessment indicated the resident was alert and orientated, and experienced periodic behavioral outbursts with verbal aggression.

The incident report indicated that an unlicensed staff personnel was physically assaulted by the resident during the resident's episode of escalated behavior. The incident report indicated the unlicensed staff personnel responded to the escalated behavior according to her training and to the best of her ability. The situation escalated rapidly resulting in injuries to the unlicensed staff personnel.

Video surveillance review showed footage of the altercation in the hallway from the perspective of the adjacent living room. The start of the physical altercation was not captured by the angle of surveillance. The physical altercation moved into view near the living room and the resident is observed shoving the head of the unlicensed staff personnel and hitting her in the head repeatedly. The altercation moved back down the hallway where the unlicensed staff personnel was then observed with her arm in the air behind her before visual was lost by the angle of the camera. The unlicensed staff personnel's hand was open. The altercation continued out of frame but was confirmed by audio. When the resident and the unlicensed staff personnel came back into view, the resident threw the unlicensed staff personnel to the floor. The resident is then observed striking the unlicensed staff personnel on the floor repeatedly. The resident moved the unlicensed staff personnel on the floor to the living room and continued to strike the unlicensed staff personnel. The resident was heard on audio stating the unlicensed staff personnel spit on her. Another resident entered the camera footage from the hallway, and the resident told her to call 911. The resident held the unlicensed staff personnel by the back of the head/neck on the floor face down. The resident struck the unlicensed staff personnel's head on the floor intermittently until law enforcement arrived.

The law enforcement report indicated officers observed the resident holding the unlicensed staff personnel down on the floor when they arrived. The unlicensed staff personnel obtained several injuries to her head. The resident was observed to have a small mark under the eye. Both the unlicensed staff personnel and the resident were evaluated at hospitals. The report indicated the emergency room doctor recommended the unlicensed staff personnel see an eye specialist and may need surgical repair for an eye injury. The resident was found to have a fracture to her finger.

During an interview, the manager stated when residents escalated in behavior, staff were trained to engage in verbal conversation with the resident to de-escalate. The manager stated the unlicensed staff personnel engaged in conversation with the resident about turning the stove off two times, and at the third verbal engagement, the resident began hitting the unlicensed staff personnel. The manager stated he believed the unlicensed staff personnel did strike the resident in self-defense after being struck multiple times by the resident.

During an interview, another resident stated she did not observe the unlicensed staff personnel hit the resident.

During an interview, the unlicensed staff personnel stated she observed the stove on with no one cooking at that time. She asked the resident if she was going to cook and reminded the resident that having the stove on when not cooking was dangerous. The unlicensed staff personnel reported the resident came up behind her, pulled her to the floor and began hitting her. The unlicensed staff personnel stated she tried to call 911 and was unable to as the resident was striking her. The unlicensed staff personnel stated she was unable to defend herself against the resident because the resident had her by the hair on the floor until law enforcement came. The unlicensed staff personnel denied ever striking the resident.

During an interview the resident stated she did not understand why the unlicensed staff personnel was questioning her about the stove being on and felt the unlicensed staff personnel was aggressive in questioning. The resident stated that during the argument, she felt spit landed on her face and then felt she had to defend herself by engaging in a physical altercation. The resident stated the unlicensed staff personnel struck her two or three times with a closed fist.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: No, attempts made were not successful.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility investigated the incident and the employee and the resident were evaluated at the hospital.

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35083	A. BUILDING: _____ B. WING _____	C 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHASE COURAGEOUS HEALTH SERVICES LL	7708 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443

(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****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482/144G.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: #HL350839082C/#HL350832521M On 4/13/2026 through 4/13/2026, 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 4 residents receiving services under the provider ' s	0 000		

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0 000	Continued From page 1 Basic/Comprehensive Home Care Assisted Living/Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL350839082C/#HL350832521M , tag identification 2310.	0 000		
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 interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards when licensee staff failed to complete an accurate assessment and failed to update the service plan with updated interventions for one of one resident (R1) following increased behaviors resulting in R1 assaulting a staff member. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	02310	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.	

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02310	Continued From page 2 The findings include: R1's diagnoses included schizophrenia, anxiety, and post-traumatic stress disorder (PTSD). The service plan dated and signed June 25, 2025, indicated interventions where in place when R1 was experiencing anxiety or depression however had no service plan interventions in place if R1 was experiencing agitation. The signed service plan indicated R1 was cooperative. R1's 90-day reassessment dated Janurary 7, 2026, indicated R1 had aggressive behaviors and there were no updates or changes to the service plan. R1's progress notes dated November 19, 2025, through February 25, 2026, and incident reports dated November 4, 2025, through March 1, 2026: - November 4, 2025: R1 struck a staff member with a bowl and 911 was called. - November 19, 2025: R1 presented with impulsivity and aggression with staff when her needs were not met. - December 10, 2025: R1 presented with outbursts and aggressive behavior. No updates to the service plan were made. - December 24, 2025: R1 was noncompliant, continued with aggressive behaviors and were not redirectable. - December 31, 2025: R1 continued with outbursts and aggressive behaviors. - January 7, 2026: R1 continued with loud and aggressive behaviors and indicated there were no new orders. - February 4, 2026: R1 continued with aggressive behavior.	02310	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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02310	Continued From page 3 - February 11, 2026: R1 continued with aggression and was spitting on staff. - February 17, 2026: R1 was yelling and spitting at staff. - February 25, 2026: R1 was noncompliant even after redirection and education. R1 continued to be loud and impulsive. - March 1, 2026: R1 attacked a staff member by hitting them. The incident report indicated R1 threated staff she was going to beat her and "get rid of her." R1's medical record lacked evidence the licensee updated interventions after R1's reassessment on January 7, 2026 when R1 had continued aggressive behviors. On April 20, 2026 at 10:02 am the facility manager stated R1 would go from pleasant and cooperative to unable to redirect with violent outbursts. The agitation had increased over eight months. The facility manager stated routinely new assessments are prompted by changes in behavior, and if the resident has new needs it would prompt an update to the service plan. The licensee's Service Plan Policy, undated, indicated assessments of the resident would determine any changes in types of services. The licensee's Comprehensive Assessment Policy, undated, indicated ongoing assessments would be completed based on changes in condition of the resident. The policy also indicated assessments are the foundation for establishing a service plan that reflects resident needs. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		