Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #:
HL370907683M, HL370907762M

Date Concluded: December 31, 2025

Compliance #:
HL370902240C, HL370907866C

Name, Address, and County of Licensee Investigated:
Bright Path Homes
6800 Quail Avenue North
Brooklyn Center, Minnesota 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, RN
Special Investigator

Finding: Substantiated, facility and individual 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 resident 1, resident 2, resident 3, and resident 4, when the facility failed to implement interventions to help reduce resident 1's risk for starting fires in his room. Additionally, the facility neglected resident 1, resident 2, resident 3, and resident 4 when the facility failed to maintain an environmentally safe facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility and the AP were responsible for the maltreatment. Resident 1, resident 2, resident 3, and resident 4 were neglected. The facility and the AP, who was the licensed assisted living director and owner, failed to implement interventions to help reduce the risk of resident 1 starting fires and harming himself or others. Resident 1 had a history of starting fires in the house and smoked indoors. The facility staff's intervention was to tell resident 1 to stop, which was ineffective.

Resident 1 was physically destructive and violent towards staff and other residents. The facility staff and the AP failed to keep the facility and resident rooms in a general state of good repair for the health and safety of the resident 1, resident 3 and resident 4. Resident 2's room was in fair condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members and case managers. The investigation included review of resident records, facility incident reports, personnel files, staff schedules, law enforcement reports, and related facility policy and procedures. Also, the investigator observed each of the resident's bedrooms, the kitchen, living spaces, and bathrooms.

Resident 1 resided in an assisted living facility. Resident 1's diagnoses included mental health diagnoses. Resident 1's service plan included assistance with managing behaviors including agitation, physical aggression, and property destruction, and housekeeping three times per day.

Resident 1's mental health care plan created three years prior to the onsite visit, indicated all of the service plan behaviors with managed with a "check all that apply" interventions and not individualized person-centered interventions. The inventions include speaking to the resident in a calm voice, provide a calm environment, redirection, provide one-to-one attention and call 911 in a mental health crisis.

Resident 1's routine assessment completed seven months prior to the onsite visit indicated resident 1 smoked cigarettes, tobacco and vaped. The assessment indicated resident 1 had "uncontrollable behaviors", broke things, trash in his room and punched holes in the walls. The assessment indicated two months prior resident 1 punched a hole in the wall and fractured his right hand. Resident 1 refused psychiatry appointments. The assessment indicated there were no changes to his care plan and indicated his behaviors continued to be managed, which was a contradiction from having uncontrollable behaviors. Resident 1's record did not include a smoking assessment to assess his ability to smoke safely.

Resident 2 resided in an assisted living facility. Resident 2's diagnoses included mental health diagnoses. Resident 2's service plan included assistance with managing behaviors including agitation, verbal aggression, and property destruction, and housekeeping three times per day. Resident 2's assessment identified resident 2 as being at risk for being abused.

Resident 3 resided in an assisted living facility. Resident 3's diagnoses included mental health diagnoses. Resident 3's service plan included assistance with managing behaviors including agitation, physical aggression, and property destruction, and housekeeping three times per day. Resident 3's assessment indicated because resident 3 had refused to have staff clean his room, resident 3 was responsible for cleaning it. The assessment indicated staff maintained the environment and managed it to maintain safety. The assessment also indicated staff cleaned his

bathroom. The assessment failed to identify if resident 3 was at risk to be abused and only indicated resident 3 was a vulnerable adult.

Resident 4 resided in an assisted living facility. Resident 4's diagnoses included a right leg amputation and falls. Resident 4's service plan included assistance with managing behaviors including agitation, physical aggression, and property destruction, and housekeeping three times per day. Resident 4's assessment indicated staff performed housekeeping daily and maintained housekeeping due to needing frequent room cleaning. The assessment failed to identify if resident 4 was at risk to be abused but indicated resident 4 was a vulnerable adult living in a facility with other vulnerable adults.

NEGLECT OF RESIDENT SAFETY

An incident report from about one year prior to the onsite visit indicated resident 1 started a fire in his room, and the fire alarm in his room went off. Resident 1 called 911, law enforcement arrived, and resident 1 requested to go to the hospital. Staff notified management. The incident report did not include any further action or intervention taken by staff.

A law enforcement report from about nine months prior to the onsite visit indicated resident 1 had been violent towards another resident and had been trying to break down the resident's door. Resident 1 had a knife but gave it to law enforcement.

A law enforcement report from about nine months prior to the onsite visit indicated resident 1 had been smoking in the facility, hitting things against walls, and broke the window in his room using a broom.

A law enforcement report from about two and a half months prior to the onsite visit indicated resident 1 had been hallucinating and yelling about voices for about one week. Resident 1 voluntarily went to the hospital.

A progress note about two months prior to the investigation's onsite visit, indicated staff reported resident 1 had been banging chairs on the table and acting extremely aggressive toward staff. Staff tried to redirect him, but resident 1's behaviors continued. Staff went outside to get away from resident 1, but he went after the staff member, chasing her with a chair. Resident 1 later took rocks and threw them through the window, breaking it. Staff called 911, but resident 1 continued after law enforcement left.

A progress note about two months prior to the onsite visit indicated resident 1 continued to have extreme behaviors of destroying properties and aggression toward staff and others. The note indicated staff would implement new medication orders and continue to manage behaviors.

An incident report from about two months prior to the onsite visit indicated resident 1 went into the kitchen, took off his pants, and urinated on the kitchen floor after a previous incident

with staff. The staff response or action taken included cleaning the floor and notifying the supervisor and nurse. The incident report did not include any intervention or further action taken by staff.

An incident report from about two months prior to the onsite visit indicated resident 1 asked staff to call for an ambulance due to having suicidal thoughts. Staff called for an ambulance, and resident 1 went to the hospital. Staff notified management. The incident report did not include any further action taken by staff.

Resident 1's record lacked a nursing assessment post emergency room visit for suicidal ideation. Resident 1's nursing assessment completed one week later (two months late from the next required 90-day reassessment) indicated it was a "new admission" because it was a new electronic health record system, but resident 1 had been a resident for two years. Resident 1 had admitted to the facility after being in jail. The assessment failed to assess the resident's recent suicidal ideation. The assessment indicated behavior interventions included having resident 1 help bring in groceries, take out the trash and clean his own room. The assessment indicated resident 1 frequently refused medications resulting in exhibited behaviors and experienced hallucinations, however the assessment failed to include interventions to attempt compliance with medication administration. Resident 1's assessment indicated resident 1 could be verbally and physically aggressive towards staff and others. Resident 1 would intentionally turn on the stove then leave the area. The assessment indicated resident 1 had severely impaired decision making, and medications had not been controlling his mental illness "lately." Although the assessment indicated he had a "smoker's cough" and a history of smoking, the assessment failed to identify resident 1 as a current smoker or indicate he displayed unsafe smoking habits. The assessment also failed to include specific measures to help reduce the risk of resident 1 abusing other residents or himself.

Resident 1's record failed to include documentation of coordinating care with resident 1's psychiatrist or case managers to manage resident 1's behaviors. Resident 1's mental health care plan had not been updated since three years prior with new interventions. Resident 1's record lacked evidence of attempting any smoking cessation products or interventions.

An incident report from about one month prior to the onsite visit indicated resident 1 displayed extreme agitation and destroyed one of the kitchen cabinets. The staff response or action included asking him to stop. The incident report indicated a nurse or supervisor had been notified. The incident report did not include any other interventions or action taken by the facility.

A progress note about two weeks prior to the onsite visit indicated resident 1 began punching and kicking the medication cabinet. Staff intervened by telling him to stop. The report indicated staff wanted to find out possible triggers, but there were not any.

A law enforcement report from the evening of the onsite visit indicated resident 1 became upset with a staff member, grabbed a pole from the bedroom, and began hitting her.

Resident 1's record lacked assessment after resident 1's violence against a staff member or implement interventions to keep him safe from others.

NEGLECT OF ENVIRONMENT
During an onsite visit, several observations were made of the facility.

Resident 1's room had several holes in the walls with writing, hoarded debris, and liquid on the walls. There was a dirty mattress on the floor with a lighter, hoarded debris, ash, and burn marks in the mattress and blanket. The floor was dirty with garbage, debris, and ash. A small table and minifridge with food had ash, tobacco paraphernalia, and debris on it. There was a piece of trim that had been adhered to the windowsill to cover burn marks. The trim failed to cover all the burn marks. The window was open without a screen. The room smelled of smoke.

Resident 2's room had boxes of garbage and a malodor in the room.

Resident 3's room had a large hole in one of the walls, several holes in the door, dents and holes in walls, and a substantial amount of food, garbage, clothing, and personal belongings on the floor throughout the room. The mattress which did not have a bedsheet, sat on a box spring mattress that was too small for the mattress. The egress window did not work, and one of the closet doors did not work.

Resident 4's room had a dirty mattress stacked on top of two box spring mattresses. The floor smelled of urine, and the flooring started lifting and warping, presumably due to liquid exposure. A wall and the doorframe had damage. There was what appeared to be feces on the floor. The wall above the mattress was also discolored and dirty.

In the kitchen, cabinets had holes and entire panels removed from them, exposing the contents of the cupboards. Additionally, there was a window with broken glass.

In the main level living room, there was a burn mark in the couch.

In the basement living room, there were several burn marks in the couch. The area also included a fire extinguisher placed on the floor in the corner of the room. The tag on the extinguisher indicated it was two months past due for being serviced. The living room to laundry room doorway had a door. The door handle had put a hole in the wall.

The basement bathroom had a medicine cabinet-style mirror pulled away from the wall, appearing as though it could fall off the wall and into the sink, a hole in the wall, a non-working bath fan, and an unclean shower with areas of black-colored growth.

Additionally, an engineering specialist also was onsite with the investigator following up on the fourth issuances of environmental and fire safety licensing violations over the past year. The engineer required smoke alarm testing and found none of the smoke alarms were interconnected as required. Additionally, the smoke alarm in the first-floor hallway (near the resident bedrooms) failed to operate.

The AP provided a repair invoice after the onsite visit for home repairs. The invoice included a false business name and false business address.

The facility provided a video after the onsite visit of resident 1 continuing to smoke indoors. The AP told the resident he cannot smoke inside because now the facility license is in jeopardy. Resident 1 stated sometimes it was hard to go outside. The AP stated, “then don’t smoke.” Resident 1 stated, “I’ll try not to.”

During an interview, ULP-1 stated resident 1 always smoked in his room. ULP-1 talked to resident 1 many times, and the intervention in place was to request he go outside to smoke. Resident 1 hardly followed the instruction. If he did listen, as soon as coming back into the facility, he would do the same thing. Resident 1 also became aggressive. When resident 1 damaged facility property, like kitchen cabinets and a window, the staff usually called 911. Resident 1 also started a fire in his room about a year prior, but also, he always played with fire in his room. Although ULP-1 only knew about one fire, he stated not every staff might report a fire, if there had been another one. Staff also had to watch him while near the stove and tell him to leave because he would turn on the stove. Regarding resident 3’s room, ULP-1 stated he knew about the hole in his wall but did not know about other maintenance issues.

During an interview, ULP-2 stated resident 1 received room cleaning as one of his services. ULP-2 described resident 1’s behavior as very bad. Every day, resident 1 smoked in his room. Sometimes, he would light paper on fire. When staff came into his room, he said he wanted to burn down the facility. When seeing him smoking or lighting paper on fire, staff would try to tell him it was not safe for him. When something like that happened, staff would give the information to the AP or sometimes complete an incident report, then they would just let it be. Every other day, morning shift went into resident 1’s room and got it cleaned up, but he would put everything back on the floor after. ULP-2 stated the holes in resident 1’s room had been there for a while. The holes in the kitchen had been there for about three weeks. The first time, the holes in the kitchen were fixed, but the holes were made again, so they were told to just let it be. No one was going to be sent out to fix the cupboards. For resident 1’s behaviors, ULP-2 did not know if anything could be done. Regarding resident 2, ULP-2 stated he liked cleaning his own room, but staff helped by getting the garbage out. ULP-2 described resident 3 as aggressive and did not want staff helping him with anything. Staff did clean the bathroom though. ULP-2 described resident 4 as very aggressive with staff, with everything making her mad. Resident 4 would urinate in her room, making her room smell.

During an interview, the nurse stated resident 1 had poor impulse control and a lot of behavioral issues. Resident 1's behaviors had been hard to manage. Interventions in place were mostly redirection which usually did not work. When his behaviors escalated, he became uncontrollable and did not really care. Staff monitored him closely while in the house and checked on him frequently while in his room. Sometimes staff could get resident 1 to go outside to smoke, but sometimes he would just ignore staff and do what he wants. If resident 1 refused to go outside to smoke, they would call the community's mobile crisis response and call another staff member. If his behavior escalated, they called 911. Because resident 1 kept putting holes in the walls, the AP was not going to fix the walls in his room; they were just going to work on relocation. The nurse stated resident 3 only allowed staff to clean the bathroom. Laundry services used to be offered, but they were not currently due to it becoming an issue. The nurse described resident 3 as uncooperative, a challenging resident, and as having severe behavior issues. Regarding the cleaning schedule, they were planned for weekly and as needed. Resident 1 and resident 4 usually received daily cleaning due to the severity of their messes. The nurse stated if resident 3 had a hole in his wall, it would have been from resident 3 pushing the wall and causing the hole himself. The nurse stated she had not been in resident 3's room for a very long time. The nurse denied knowing about resident 3's window, closet door, and vent being broken.

During an interview, the AP stated all the residents reviewed the whole package of waiver services. The AP stated they had issues with resident 1 smoking in his room. Interventions for this issue included telling him to go outside to smoke and having buckets for cigarettes outside both doors of the facility. The AP stated dealing with mental health has been very challenging. Sometimes resident 1 refused, and all the facility could do is keep monitoring and encouraging him to go outside and smoke. Resident 1 also displayed extreme aggression, tearing the house down, punching the doors and walls, urinating on the floors in the kitchen and walls in his room, and broke a window using rocks. The AP stated they met with case managers multiple times to discuss relocation, but nothing came from the meetings. The AP stated they manage his behaviors as best as they can, but it had been an ongoing challenge. Regarding a fire resident 1 had started in his room, the AP had been informed there was a small fire, but staff were able to take care of it, and nothing happened. The AP stated he did not know every fire incident was supposed to be reported to the state, and he did not know if 911 had been called for that fire. Regarding resident 1 turning on the stove, the AP stated resident 1 used the stove to light his cigarettes when he did not have a lighter. He encouraged and trained staff to intervene and turn the stove off when resident 1 tried to do that. Recently, they asked resident 1 to move into a different room to repair everything. They re-did the floors, walls, and got a new mattress. But resident 1 came back in and made it to be the way it was during the onsite visit. The AP stated after they discharge him, they would go ahead with completing the repairs. Regarding resident 3, the AP stated his anger made it very difficult to implement things like housekeeping. They got his family member to work with them because he had accused staff of stealing things from his room. The AP stated he instructed his staff to keep trying to get him to let them clean. Regarding the incident between resident 1 and resident 3 causing a hole, the AP stated he would not know if the hole was due to that, and at the time, he did not see a hole. The AP did

not know when the hole got there or when it got bigger. The AP denied being aware of a broken window in resident 3's room. The AP stated he did not know about the vent not working or the closet door not working. The AP stated resident 3 was too confrontational, and he had not had a chance to tour his room. Resident 4 tended to refuse services and tended to retaliate when not happy with something. Resident 4's mattress has been replaced multiple times. Regarding the staff cleaning schedule, there were certain days for certain residents.

During an interview, resident 1 stated staff usually did not say anything to him about smoking inside until it started bothering them. It took staff a couple days of him smoking inside for them to tell him to go outside to smoke. Resident 1 stated he hit the walls daily. Resident 1 stated some staff did not say anything to him when he destroyed property. Resident 1 has been trying to move out for the last couple of years. He went to the hospital several times because he did not want to come back to the facility. Resident 1 stated staff did not cook or clean, violated his rights, and could not talk to staff, so he tried to stay in his room.

During an interview, resident 3 stated his cleaning services had been revoked due to hundreds of dollars' worth of his personal belongings being taken or going missing. Regarding other areas of the facility, staff did not clean enough. Resident 3 stated staff did not really do anything and slept during their shifts. Resident 3 stated another resident at the facility would strike out, attack, and threaten to kill people. Resident 3 stated he tried to not be around others while in the facility. Resident 3 stated he believed he has been living with a mold infestation or dust issue because he cannot breathe well and has skin problems only when at the facility. Regarding the hole formed from being attacked, it had been there for over one year. Insects would crawl in and out of the hole. No one has come into his room to discuss the holes, the window, or the closet door.

During an interview, resident 4 stated staff yell at her. One staff member does not even talk to her. Resident 4 did not get offered supper by one of the staff. Resident 4 stated one of the other residents smoked in his room. The smoke would go into the hallway and then into her room.

During an interview, resident 1's case manager stated the facility staff were supposed to teach activities of daily living skills. Resident 1 told him he broke the window about three months prior because staff made him angry. Resident 1 usually called law enforcement on himself because he did not want to be at the facility. Resident 1 has reported not getting along with certain staff. One time, resident 1 asked for an as needed medication but staff did not give it to him. They got into a verbal argument, and resident 1 tried to go into his room, but staff blocked him, not allowing him to go into his room. So, resident 1 grabbed a pipe and tapped her with it. Resident 1's case manager stated he had never been in resident 1's room, so he had not seen the inside of his room. Resident 1's case manager stated the nurse had recently told him things were going well regarding resident 1's behaviors. Resident 1's case manager stated he did not know anything about resident 1 smoking in his room.

During an interview, resident 2's case manager stated resident 1 has been a trigger for resident 2's mental health. Resident 2 had not been at peace and his mental health had not been stable at the facility. Resident 2's case manager stated he made several reports to management. Resident 2's case manager identified his biggest concern has as the AP bringing in residents whose care levels were beyond what the facility could provide. There had been a lot of harassment and an invasion of resident 2's privacy, with people entering his room. Recently, resident 2's case manager had to go to the facility to complain about resident 1 smoking inside his room. Resident 2's case manager stated resident 1 has been impulsive and has been a risk to everyone, including staff. Resident 2's case manager stated resident 2 was not safe at the facility, stayed locked in his room, and did not want to come out.

During an interview, resident 3's family member stated after resident 3 moved in, staff told him because he was 18, he did not need to take his medications anymore. So, resident 3 no longer took any medications despite the family member and the psychiatric provider's opinion about it. Resident 3 has been attacked by another resident several times (resident 1). On one of those occasions, which happened more than one year prior to the onsite visit, resident 1, who was known to be violent, put resident 3 through the wall in his room. Resident 3's family member stated the AP had said the hole would be fixed within a couple of days, but that never happened. The hole remained in his wall to the date of the interview. Resident 3's family member stated she has cleaned resident 3's room several times. A few months prior to the interview was the worst she had ever seen his room. She found what she called black mold on the floor and on the plastic to his mattress. This visit was when she discovered the window did not open. She asked someone to open it, but was told it did not work. Resident 3's family member had gone two other times since then to clean. Resident 3's family member stated resident 3's mattress was a queen, but the box spring was a double. The closet door did not close, and the vent did not open. More recently, she discovered resident 3's vent did not work. When she told a staff member, the staff member just shook her head. Resident 3's family member bought resident 3 a heater and a fan. She also brought him a small refrigerator, but it broke and had been sitting in the basement living room for several months. Resident 3's family member stated she tried to talk to the AP several times. Resident 3's family member described it there as a very hostile environment. When she recently went to the facility, resident 1 had been tearing up the cabinets in the kitchen, so she stayed downstairs until she knew he was no longer in the kitchen. Resident 3's family member stated resident 3 did not feel safe at the facility. Resident 3's family member stated the AP told the facility staff she was not allowed in the facility but was recently able to enter due to newer staff working who did not know her.

During an interview, resident 4's case manager stated the facility windows and doors were open (in winter) when she went to visit resident 4 recently (after the investigator's onsite visit), so the facility felt cold and drafty. Unlike the first time she met with resident 4 at the facility, resident 4's bedroom appeared clean. Resident 4, however, smelled and looked like she had not showered in a long time. Resident 4's case manager did not think she had been receiving all the services she should, even though the facility has been getting reimbursed for all the services. Resident 4 reported she did not receive help in some areas. Overall, resident 4's case manager

thought it had been going better at the facility than previously but not going great. Resident 4 had not been thriving, and the case manager got the impression resident 4 seemed unhappy living there.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):
(1) The facility and the AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The AP directed an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility failed to provide adequate staffing levels.

The AP followed the facility directive and/or policies and procedures.

The AP had the authority to direct and implement operational regulatory requirements or make operational changes.

(3) The facility and the AP failed to follow professional standards and/or exercise professional judgement.

The facility and the AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed:
Resident 1: Yes.
Resident 2: No; resident declined.
Resident 3: Yes.
Resident 4: Yes.

Family/Responsible Party interviewed:
Resident 1: Not applicable.
Resident 2: Not applicable.
Resident 3: Yes.
Resident 4: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The staff asked resident 1 to stop smoking in the house.

Action taken by the Minnesota Department of Health:
MDH previously investigated the complaint investigation, HL370902240C and 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 Center City Attorney
Brooklyn Center Police Department
Minnesota 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
	37090	A. BUILDING: _____ B. WING _____	C 11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT PATH HOMES LLC	6800 QUAIL AVENUE NORTH BROOKLYN CENTER, MN 55429

(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: HL370907866C/HL370907762M HL370902240C/HL370907683M On November 13, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 4 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for HL370907866C/HL370907762M and HL370902240C/HL370907683M, tag identification 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37090	A. BUILDING: _____ B. WING _____	C 11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT PATH HOMES LLC	6800 QUAIL AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
02360	Continued From page 1 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 and an individual person were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		