Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL373221140M
Compliance #: HL373225240C

Date Concluded: July 28, 2026

Name, Address, and County of Licensee Investigated:
Bright Path Homes
6600 Central Avenue Northeast
Fridley, MN 55432
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Maerin Renee, 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 the resident when he used illicit drugs in his room and experienced an overdose, requiring hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident experienced an accidental drug overdose in his apartment while his girlfriend visited. A court order was in place instructing the resident to have no contact with his girlfriend. The resident had a separate entrance to his apartment, so staff did not know the resident's girlfriend was in his apartment. The resident was aware of the facility's rules, as he had signed a document indicating he understood the facility did not allow residents and guests to engage in illegal drug use while living at the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The

investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia and cocaine abuse. The resident's services included assistance with housekeeping and medication management. The resident's assessment indicated he was independent with most activities of daily living but required help with finances, appointments, meals, transportation, and medications.

The resident's progress notes indicated he passed out in his apartment around 1:00 a.m. The resident's girlfriend was with him and called 911. Emergency services personnel (EMS) and the police arrived. Police administered cardiopulmonary resuscitation (CPR) and the resident regained consciousness. EMS transported the resident to the hospital. The resident's girlfriend said she did not know what happened and only saw him fall, after which she called the police. The staff member told the girlfriend to leave, as she and the resident had an incident the last time she visited and she had been instructed to not return to the facility.

A court order completed a few weeks prior to the incident instructed the resident to not contact his girlfriend any further. A police report was requested but not provided.

The resident's hospital records indicated his girlfriend said she called 911 after the resident became unresponsive. At the facility, police administered two doses of Narcan, which revived the resident. EMS transported the resident to the hospital, where he was diagnosed with an accidental overdose. The resident's vital signs were within normal limits, the resident's demeanor was calm, and he denied pain. The resident said he had smoked crack cocaine but denied having used anything else. The resident tested "non-negative" for cocaine, all other drugs tested were below the screening threshold. The resident was monitored in the emergency department for several hours and then medically cleared for discharge. Facility staff transported the resident back to the facility.

A document titled Lease Addendum for Crime-Free/Drug-Free housing was signed by the resident in several years prior. Among many stipulations, the document indicated the resident, members of the resident's household, or guests would not engage in illegal activity, including drug-related illegal activity, on or near the premises. After this incident, the resident signed an additional attestation indicating he would follow the policies of the facility or risk termination of his lease.

When interviewed, an administrator said the resident's girlfriend had previously attempted to establish residency in the resident's apartment, which led to an altercation between the two of them. The girlfriend continued to try to come back for several months, before moving on. Staff did not believe the girlfriend was a good influence on the resident, who was jailed multiple times in response to interactions with her. After the resident's overdose, nursing updated his

care plan and he signed a visitation policy. The resident had previously signed a document addressing the prohibition against using alcohol or illegal drugs in the facility. After the resident returned to the facility he apologized for his behavior and had been adhering to the facility's rules.

When interviewed, a supervisor said every time the resident's girlfriend came to the facility, there was a problem. The facility eventually paid for the resident's girlfriend to live in a hotel for a month before she relocated elsewhere. Staff did not know the girlfriend was at the facility the night the resident overdosed until the police and ambulance arrived early in the morning. Since the resident returned and his girlfriend moved away there have been no major issues with the resident and he was doing well.

When interviewed, the resident said his ex-girlfriend had stopped by to drop off his wallet, because she had stolen it from him. The resident said he wanted closure with her, to let her know it was over. The two of them eventually started to use drugs in the resident's apartment. The resident said he had two grams of Fentanyl and the last thing he remembered was sitting down on the couch next to his ex-girlfriend. The resident said he awakened, and the fire department, ambulance, and police personnel were standing over him. The resident said he was taken to the hospital where he was monitored for several hours before being released back to the facility. The resident entered treatment and then returned to the facility while his ex-girlfriend moved back to the East coast. The resident felt supported by staff at the facility.

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: Yes.
Family/Responsible Party interviewed: No, the resident is his own decision-maker.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

Nursing updated the resident's care plan and reviewed facility policies with the resident.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37322	A. BUILDING: _____ B. WING _____	C 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT PATH HOMES LLC	6600 CENTRAL AVENUE NE FRIDLEY, MN 55432

(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 On June 10, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL373225240C/#HL373221140M. No correction orders are issued.	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.	