*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report:** HL373782822M
**Compliance:** HL373781156C

**Date Concluded:** July 14, 2026

**Name, Address, and County of Licensee Investigated:**
Care Partners Home Care
3508 83rd Ave N
Brooklyn Park MN 55443
Hennepin County

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

**Evaluator's Name:** Maggie Regnier, 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 they did not call 911 immediately when the resident was found unresponsive.

**Investigative Findings and Conclusion:** The Minnesota Department of Health determined neglect was not substantiated. The resident was unresponsive, and staff called the nurse. The nurse arrived at the facility within minutes to assess the resident and called 911 at which point. The resident passed away.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case manager and law enforcement. The investigation included review of the resident record, death record, hospital records, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed staff interactions between staff, visitors and residents.

The resident resided in an assisted living facility. The residents' diagnoses included paranoid schizophrenia, heart failure, and respiratory failure with oxygen dependency. The resident's service plan included assistance with showering, some transferring, medication management and meals. The resident's assessment indicated she was wheelchair bound, had a trach (hole in the front of the throat which provides an alternate pathway for air to enter the lungs) and was oxygen dependent and needed some assistance at times with transferring.

A report indicated the resident was found unresponsive, the staff called the nurse, the nurse instructed staff to briskly rub the resident's chest to arouse the resident. The nurse arrived minutes later and called 911 while initiating CPR. Emergency medical staff declared the resident had deceased after attempts to resuscitate were futile.

The medical examiner cause of death report indicated the resident's cause of death was cardiomegaly (enlarged heart) with four-chamber enlargement. Contributing factors included history of congestive heart failure, chronic respiratory failure with tracheostomy dependence, and epilepsy.

During an interview, a nurse stated she was called by a staff member stating the resident was sitting on the couch, not responding. The nurse stated she was a few minutes away from the facility and instructed the staff member to briskly rub the residents chest to try to arouse her. When the nurse arrived, she assessed the resident, began CPR, and 911 was called. The resident was later pronounced deceased.

During an interview, the staff member reported the resident was sitting on the couch and asked for a drink of water, which the staff member did get for the resident. The staff member stated one hour later, the resident was not responsive, sitting on the couch and breathing abnormally so she called the nurse. The staff member stated the nurse was a few minutes away and was told to rub the resident chest to try to arouse her, but this was ineffective.

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

**"Not Substantiated" means:** An investigatory conclusion indicating the preponderance of evidence shows 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, deceased
**Family/Responsible Party interviewed**: None
**Alleged Perpetrator interviewed**: Not Applicable

**Action taken by facility:** The staff member called the nurse when it was determined the resident was unresponsive.

**Action taken by the Minnesota Department of Health:** No further action 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 |
|---|---|---|---|
| | 37378 | A. BUILDING: _____ B. WING _____ | C 04/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CARE PARTNERS HOMECARE LLC | 3508 83RD AVENUE NORTH BROOKLYN CENTER, 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<br><br>On April 9, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL373781156C/#HL373782822M. No correction orders are issued. | 0 000 | | |