Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL350833706M
Compliance #: HL350833570C

Date Concluded: August 31, 2026

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Lacey Eggersdorfer, RN, Special Investigator

Finding: Substantiated, facility 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 provide interventions when resident #1 had behaviors.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment of resident #1, resident #2, resident #3 and resident #4. The facility was aware that resident #1 had violent behaviors prior to admission and failed to implement a behavior management plan. That led to risk of harm to all residents in the facility, as well as documented decline in mental health of resident #2 and resident #3. Staff documented being afraid of resident #1 multiple times and that prevented staff from completing necessary safety checks on other residents.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted 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 interactions between staff and residents.

Resident #1

Resident #1 resided in an assisted living facility. His diagnoses included schizophrenia, anxiety, and post-traumatic stress disorder. His service plan included assistance with managing behaviors. Resident #1's assessment indicated he had behaviors of isolating himself as well as being resistant to taking medications.

Medical record reviewed for resident #1 indicated the facility was aware he had a history of violent behaviors and was at risk of harming himself and others. He was provisionally discharged (a conditional release of a patient from a treatment center) to the facility under the condition he remained compliant with medications and abstained from harmful behaviors. Resident #1's medical record lacked any behavior management plan implemented by the facility.

Further medical record review indicated resident #1 started displaying violent behavior three days after admission to the facility and behaviors continued for three months. Recorded behaviors involving resident #1 included but were not limited to the following:

An incident report indicated that when a staff member was taking another resident out of the facility, resident #1 rushed staff with a knife, and questioned what the staff member was doing. The incident report indicated a supervisor later spoke with resident #1 about the incident.

An incident report indicated resident #1 was smoking inside the facility. When staff attempted to redirect him to smoke in the designated area outside, resident #1 threatened staff and continued smoking inside all night. Other residents in the facility were noted to have difficulty breathing. The progress note indicated staff informed the manager, but no manager spoke to resident #1 about smoking inside the facility.

An incident report indicated that other residents were concerned when resident #1 brought a gun into the facility. The incident report indicated the resident told the manager it was a toy gun.

An incident report indicated resident #1 cut off electricity to the facility. When staff attempted to turn electricity back on for all residents, resident #1 rushed the staff and prevented the electricity from being turned on. This incident report indicated police were called to de-escalate resident #1.

An incident report indicated resident #1 had broken into rooms with a screwdriver and turned off electricity and the furnace in the facility. The incident report indicated resident #1 was uncooperative and agitated with staff redirection.

An incident report indicated resident #1 had broken into a resident's room and broke their bed. The incident report indicated the follow up needed after the incident was for staff to continue to monitor resident #1's behavior.

An incident report indicated resident #1 broke into the facility office while a staff member was charting and began yelling at her to get out of the facility. The staff member could not escape from the office because the resident was blocking the doorway. The staff member called 911 and police told the staff member breaking a door was not a crime. The incident report indicated the follow-up for the incident was for staff to continue to monitor his behavior.

An incident report indicated resident #1 was shooting a BB gun inside the facility and staff locked themselves in the office for safety. The staff member did not call 911 because law enforcement frequently said there was nothing they could do for resident #1. The incident report had no follow-up notes.

An incident report indicated resident #1 threatened to cut a staff member's throat. Staff did not call 911 due to police advising staff that the resident could say anything he wanted to. The staff member spent her shift in the facility office due to fear of resident #1 killing her. The incident report did not indicate if other residents in the facility were provided with their necessary services while staff sat in the office.

An incident report indicated resident #1 started a fire on the front porch of the facility while residents were in the house. Resident #1 attacked staff when they tried to put the fire out. The incident report indicated the follow up needed after the incident was for staff to continue to monitor resident #1's behavior.

An incident report indicated 911 was called after resident #1 threw a cup at a staff member. Police advised the staff member that there was nothing they could do for the situation and to reach out to the facility manager. After police left, resident #1 unplugged the facility TV while other residents were watching it. Staff attempted to contact the manager, but no manager was available. The incident report indicated resident #2 de-escalated resident #1 and told him his behavior was unacceptable.

An incident report indicated resident #2 slept near staff to keep them safe from resident #1. Resident #1 threatened to stab staff with a knife and hit staff with an object. The incident report indicated the presence of resident #2 was what kept staff safe.

A progress note indicated resident #1 opened all the doors in the facility preventing residents from sleeping.

A progress note indicated resident #1 promised to kill staff and later shot his BB gun at a staff member. The staff member locked herself in the office and called the manager, the manager told her she needed to leave the office and care for other residents in the facility. The progress note indicated the staff member remained in the office due to fear.

A progress note indicated resident #1 had called 911 for hallucinations. The progress note did not indicate a nurse was consulted for the resident's hallucinations.

A progress note indicated resident #1 was standing over staff for 30 minutes, and staff yelled for help from resident #2. Resident #2 confronted resident #1 on his behavior and resident #1 took a knife to staff. The progress note indicated 911 and the manager was called.

A progress note indicated that staff were only safe in the presence of resident #1 when resident #2 was around.

Multiple progress notes indicated resident #1 refused to allow safety checks to be completed on other residents in the facility.

Multiple progress notes indicated resident #1 broke into other resident rooms and went through their belongings. Progress notes indicated resident #1 destroyed facility property, including cameras and frequently threatened staff if they did not let him in other resident rooms.

Multiple progress notes indicated resident #1 frequently shot his BB gun off inside the facility, at staff, and at a vehicle parked in front of the facility.

Law Enforcement records indicated police responded to 911 calls to the facility involving R1's behavior ten times over two months. Reports did not indicate resident #1 was transported to the hospital for evaluation of his behavior after any of the 911 calls.

Facility staff did not conduct an assessment following the incidents to identify vulnerabilities, susceptibility to abuse, or new risks of harm to others. Existing interventions were not evaluated, and no new interventions were implemented to prevent future incidents.

Resident #2

Resident #2 resided in an assisted living facility. Her diagnoses included bipolar disorder and attention deficit hyperactivity disorder (ADHD) with hyperactive impulsivity. Resident #2's service plan included assistance with anxiety and taking medications. Resident #2's assessment

indicated she was susceptible to abuse from other individuals and had difficulty recognizing unsafe situations.

Nursing progress notes indicated resident #2 was described as pleasant and had a bright affect and was medication compliant. Resident #2 was noted to begin having behaviors of self-isolation, missing medical appointments, and not participating in outings around the time that resident #1 was admitted and had behaviors.

Facility staff did not conduct an assessment to identify vulnerabilities or susceptibility to abuse. Existing interventions were not evaluated, and no new interventions were implemented to prevent future incidents.

Resident #3

Resident #3 resided in an assisted living facility. Resident #3's diagnoses included schizophrenia and substance use disorder. Resident #3's service plan included assistance with managing behaviors of agitation. Resident #3's assessment indicated he was at risk of being abused by others, as well as at risk of abusing other vulnerable adults.

Nursing progress notes indicated resident #3 was labile and calm, sleeping well and was medication compliant leading up to resident #1's admission to the facility. Resident #3 became noncompliant with medications the week of resident #1's admission. Nursing progress notes after resident #3 became noncompliant with medications indicated he had symptoms of schizophrenia including paranoia, insomnia, disorganized thoughts and agitation. Resident #3 was resistant to de-escalation and redirection.

Review of incident reports indicated resident #3 broke facility property on multiple occasions beginning the week of resident #1's admission. Staff were threatened by resident #3 when they attempted to redirect him from breaking facility property. The incident reports did not indicate any follow-up was done after the incidents.

Review of resident #3's medical record indicated he had risk prevention strategies for physical aggression and property destruction. Staff were to de-escalate, redirect the resident, observe and document behaviors. The medical record lacked any reassessment after resident #3 had a change in condition.

Facility staff did not conduct an assessment following the incidents to identify vulnerabilities, susceptibility to abuse, or new risks of harm to others. Existing interventions were not evaluated, and no new interventions were implemented to prevent future incidents.

Resident #4

Resident #4 resided in an assisted living facility and was newly admitted. Resident #4 diagnoses included anxiety, depression, and post-traumatic stress disorder. Resident #4's service plan

included assistance with taking medications. Resident #4's assessment indicated she was at risk of being abused by other vulnerable adults.

Progress notes indicated resident #1 confronted resident #4 about a backpack she had. The progress note did not indicate why resident #1 wanted to know about the backpack and did indicate resident #4 felt threatened. Progress notes also indicated resident #4 had difficulty sleeping due to resident #3 disturbing the facility at night.

Facility staff did not consider resident #4's identified vulnerabilities and susceptibilities to abuse a high risk of harm when housed with residents who had unmanaged behaviors. Existing interventions were not evaluated, and no new interventions were implemented to prevent future incidents.

During an interview, unlicensed staff #1 stated resident #1 had made multiple threats to kill her and other unlicensed staff. He had shot the BB gun at her but missed. She stated when resident #1 had these behaviors, staff were instructed to call 911 to intervene. Unlicensed staff #1 did not indicate a nurse would be called when the resident had behaviors.

During an interview, unlicensed staff #2 stated when resident #1 or resident #3 had behaviors she would contact the manager, and nothing would happen. She recalled she once had to barricade herself in the facility's medication room with another client when resident #1 had behaviors until police arrived. She had seen both resident #1 and resident #3 threaten other residents in the home. Unlicensed staff #2 also stated the facility has only ever had one staff member on duty at a time since resident #1 and resident #3 were admitted.

During an interview, resident #2 stated she had seen resident #1 with knives, screwdrivers, and his BB gun. She stated he had potential to hurt others including staff, but she stopped him before he could be physically violent. Resident #2 also stated she was fearful of resident #3 due to him screaming and slamming doors.

During an interview, resident #4 stated she was concerned about resident #3's irritability.

During an interview, case manager #1 stated resident #1 was under conditions when he moved into the facility such as refraining from behaviors that were a threat to himself and others and being compliant with medications and medical appointments. While being noncompliant with medication was not enough to force resident #1 into hospitalization for treatment, case manager #1 considered threatening to harm others or himself would a large incident. Case manager #1 stated he found it odd that the facility considered resident #1's behavior fine until three months into resident #1's admission.

During an interview, the nurse stated she had concerns about the safety of other residents in the facility. She stated she had witnessed resident #1 in verbal altercations with other residents.

She also received reports from staff that resident #2 isolated herself in her room due to resident #1's behavior. The nurse also stated she brought up concerns about the behaviors of resident #1 and resident #3 to the manager.

During an interview, the manager stated after incident reports were reviewed, he collaborated with the nurse. He believed resident #1 and resident #3 needed reassessments and new interventions due to behaviors, but stated he never communicated that with the nurse. He assumed the nurse was implementing behavior management plans. The manager also stated he kept other residents safe by having two staff on duty.

Based on information gathered during the investigation, an interview was not conducted with resident #1 or resident #3 due to the investigators' concern that the interview process had potential to increase agitation or risk that the interview process would have adversely affected their mental state or emotional well-being.

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.

Vulnerable Adult interviewed: Resident #2 and resident #4 were interviewed. Resident #1 and resident #3 were not due to potential to increase agitation or otherwise adversely affect their mental state.
Family/Responsible Party interviewed: No, residents #1, #2, #3 and #4 were their own guardian.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility reached out to case management for resident #1 and resident #2.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department
Minnesota Board of Executives for Long Term Services and Supports
MN Department of Human Services, Office of Inspector General, Program Integrity and Oversight Division

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 07/31/2026

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****** 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: #HL350833570C/#HL350833706M On July 30, 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 Assisted Living license. The following correction orders are issued for #HL350833570C/#HL350833706M, 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	

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 07/31/2026

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	Continued From page 1	0 000	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, 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 one of one resident(s) reviewed (R1, R2, R3, and R4) was free from maltreatment. Findings include: 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.	02360		