

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report : HL357153349M
Compliance : HL357152696C

Date Concluded: September 15, 2026

Name, Address, and County of Licensee

Investigated:

All Hopes Incorporated
2509 Pearson
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lisa Coil, RN, BSN
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 abused the resident when staff attempted to confine the resident through actions such as hiding the resident's shoes and placing heavy items in front of the door to prevent the resident from leaving the facility without informing staff.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was substantiated. The facility was responsible for the maltreatment. The facility staff placed a couch in front of the stairway and placed a round key lock on the door handle to prevent the resident from leaving the facility.

The investigator conducted interviews with facility administrative staff. The investigation included review of the resident record, facility incident reports, staff schedules, related facility policy and procedures. Also, the investigator observed the resident's elopement behaviors and staff interaction with the resident.

The resident resided in an assisted living facility. The resident's diagnoses included major neuro congenital disorder (abnormalities of the nervous system), anoxic brain injury (damage to the brain due to lack of oxygen), and mental illness. The resident's service plan included assistance with medication and behavior management, including elopement. The resident's assessment indicated the resident had behaviors and risk of elopements.

An incident report indicated resident #1 went out to smoke and left the facility without notifying staff. The same document indicated resident #1 was found on a nearby street, 45 minutes later. The same document indicated resident #1's plan of care was not being followed, staff should stay with or watch resident #1 while he smokes.

A second incident report, three months later, indicated resident #1 pushed by staff and left the house. The same document indicated staff ran after resident #1 and asked resident #1 to come back but resident #1 refused. The same document indicated staff called the supervisor and the supervisor was able to talk resident #1 into returning to the facility.

Multiple progress notes, dated between the two incidents, indicated resident #1 frequently attempted to exit the facility. Nine of those progress notes indicated resident #1 left the facility and staff had to follow resident #1 to redirect him back to the facility.

During an interview, resident #1 stated he felt like a prisoner and could not go anywhere. Resident #1 stated they keep mini locks on the doors which staff have a key to open. Resident #1 stated other residents must have staff open the door when they want to go outside. Resident #1 stated the locks are not on the door right now because you [the investigator] was there.

During an interview, resident #2 stated the staff put locks on the inside door handle, a round lock with a key. Resident #2 stated he had a key to unlock the lock and showed this writer the key. Resident #2 stated prior to this door handle lock they had two metal locks on the garage door.

During an interview, the manager stated resident #1 constantly tries to leave the facility multiple times a day and does not know his way back once he walks away. The manager stated staff had put a coach in front of the stairway to prevent resident #1 from leaving the facility but they quit doing that. The manager stated staff sometimes use a lock on the door which has a key to open. The manager stated residents need to be let out of the facility by staff when the lock is on the door.

A review of the resident's medical record indicated the facility had no physician orders for any restraint.

A review of the facilities licensure indicated it did not have legal authority to create a secured unit which prevented residents from exiting the facility.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.

"Abuse" means:

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.

Vulnerable Adult interviewed: Yes.

Family/Responsible Party interviewed: No, attempted but did not reach.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: No action taken.

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 Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35715	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/31/2026
NAME OF PROVIDER OR SUPPLIER ALL HOPES INCORPORATED		STREET ADDRESS, CITY, STATE, ZIP CODE 7932 ORCHARD 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, 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: #HL357152696C/#HL357153349M On August 31, 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 3 residents receiving services under the provider ' s Assisted Living license. The following correction orders are issued for #HL357152696C/#HL357153349M, tag identification 0450, 2360, and 2370.	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.		
0 450 SS=I	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall:	0 450			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 450	Continued From page 1 (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to utilize a person-centered planning and service delivery process for one of three residents (R1) when the facility did not address the individualized person-centered interventions. In response to R1's attempts to leave the facility, the facility used locks and furniture to prevent the resident from leaving. While staff members redirected R1 back to the building, the facility did not develop interventions to address R1's needs. The facility was not licensed to provide a secured unit. This practice resulted in a level three violation (a violation that harmed a client's/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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients/residents). The interventions preventing residents from leaving could effect all residents at the facility. Three residents lived at the facility at the time of the	0 450			

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0 450	Continued From page 2 onsite visit. The findings include: R1's diagnoses included major neuro congenital disorder (abnormalities of the nervous system), anoxic brain injury (damage to the brain due to lack of oxygen), and mental illness. R1's service plan dated May 17, 2026, included R1 required assistance with medications and safety checks. The same document indicated R1 was independent with walking, and required management of multiple behaviors, including elopement threat and wandering. R1's assessment dated May 30, 2026, included interventions such as one-to-one supervision when outside, door chyme, Airtag (a tracker device) in shoe, safety checks, and monitor throughout the shift. The assessment also indicated R1 had poor memory, was forgetful, and unable to find his way back to the facility by himself. R1's incident report dated March 4, 2026, at 8:40 a.m., indicated R1 went out to smoke and left the facility without notifying staff. The same document indicated R1 was found on a nearby street, 45 minutes later. The same document indicated R1's plan of care was not being followed, staff should stay with or watch R1 while he smokes. A review of follow-up documentaiton did not identfy person-centered interventions to prevent further episodes of elopement. R1's incident report dated May 31, 2026, at 11:00 a.m., indicated R1 pushed by staff and left the house. The same document indicated staff ran after R1 and asked R1 to come back but R1	0 450			

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0 450	Continued From page 3 refused. The same document indicated staff called the supervisor and the supervisor was able to talk R1 into returning to the facility. A review of follow-up documentaiton did not identfy person-centered interventions to prevent further episodes of elopement. R1's progress notes dated April 2, 2026, at 2:23 p.m., indicated R1 was trying to sneak out aimlessly but staff redirected him back to the facility. A review of follow-up documentaiton did not identfy person-centered interventions to prevent further episodes of elopement. R1's progress notes dated April 9, 2026, at 2:01 p.m., indicated R1 left the facility a couple of times and staff ran after him. A review of follow-up documentaiton did not identfy person-centered interventions to prevent further episodes of elopement. R1's progress notes dated April 30, 2026, at 1:54 p.m., indicated R1 left the facility a couple times in the morning. Staff were able to redirect him back to the facility. A review of follow-up documentaiton did not identfy person-centered interventions to prevent further episodes of elopement. R1's progress notes dated May 4, 2026, at 12:19 p.m., indicated R1 left the facility and staff followed him to ensure safety while attempting redirection. A review of follow-up documentaiton did not	0 450			

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0 450	Continued From page 4 identfy person-centered interventions to prevent further episodes of elopement. R1's progress notes dated May 6, 2026, at 1:53 p.m., indicated R1 left the facility, staff were able to direct him back to the facility. A review of follow-up documentaiton did not identfy person-centered interventions to prevent further episodes of elopement. R1's progress notes dated May 14, 2026, at 2:00 p.m., indicated R1 ran out of the facility and staff followed him for an hour before he agreed to return. A review of follow-up documentaiton did not identfy person-centered interventions to prevent further episodes of elopement. R1's progress notes dated May 15, 2026, at 2:17 p.m., indicated R1 left the facility around 8:30 a.m. and snuck out a second time at 1:27 p.m. A review of follow-up documentaiton did not identfy person-centered interventions to prevent further episodes of elopement. R1's progress notes dated May 17, 2026, at 1:48 p.m., indicated R1 ran out of the facility several times. A review of follow-up documentaiton did not identfy person-centered interventions to prevent further episodes of elopement. R1's progress notes dated May 22, 2026, at 1:49 p.m., indicated R1 left the facility several times between 8:30 a.m. and 10:00 a.m. The same document indicated R1 was direct back to the	0 450			

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0 450	Continued From page 5 facility each time. A review of follow-up documentaiton did not identfy person-centered interventions to prevent further episodes of elopement. During an observation on August 31, 2026, at 10:40 a.m., R1 went down the step and exited the front door. The staff member went out the door after R1 but R1 was already out of sight. The staff member came back into the facility to get her car keys. The staff member had to drive down the road to pick R1 up and return him to the facility. During an interview on August 31, 2026, at 11:00 a.m., R1 stated he felt like a prisoner and couldn't go anywhere. R1 stated they keep mini locks on the doors which staff have a key to open. R1 stated other residents must have staff open the door when they want to go outside. R1 stated the locks are not on the door right now because I [the investigator] was there. During an interview, R2 stated the staff put locks on the inside door handle, a round lock with a key. R2 stated he had a key to unlock the lock and showed this writer the key. R2 stated prior to this door handle lock they had two metal locks on the garage door. During an interview, the Housing Manager (HM)-A stated R1 constantly tried to leave the facility multiple times a day and doesn't know his way back once he walks away. HM-A stated staff had put a couch in front of the stairway to prevent R1 from leaving the facility, but they quit doing that. HM-A stated staff sometimes use a lock on the door which has a key to open. HM-A stated residents need to be let out of the facility by staff when the lock is on the door.	0 450			

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0 450	Continued From page 6 The licensee-provided "Minnesota Assisted Living Bill of Rights" undated, indicated 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. The licensee-provided policy titled "Service Plan" dated December 29, 2025, indicated an individualized service plan was implemented for all residents. The policy indicated the licensee would provide all services required by the current service plan. TIME PERIOD FOR CORRECTION: Immediately	0 450			
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) 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			

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02370	Continued From page 7	02370			
02370 SS=I	144G.91 Subd. 9 Right to come and go freely Residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to allow resident's had the right to enter and leave the facility as they chose one of three residents (R1). This had the potential to affect all three residents residing at the facility. The facility blocked the stairs with a couch and placed a lock on the inside door handle which had to be unlocked with a key to get out of the facility. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included major neuro congenital disorder (abnormalities of the nervous system), anoxic brain injury (damage to the brain due to lack of oxygen), and mental illness. R1's service plan dated May 17, 2026, included R1 required assistance with medications and safety checks. The same document indicated R1 was independent with walking, and required management of multiple behavior, including elopement.	02370			

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02370	Continued From page 8 R1's incident report dated March 4, 2026, at 8:40 a.m., indicated R1 went out to smoke and left the facility without notifying staff. The same document indicated R1 was found on a nearby street, 45 minutes later. R1's incident report dated May 31, 2026, at 11:00 a.m., indicated R1 pushed by staff and left the house. The same document indicated staff ran after R1 and asked R1 to come back but R1 refused. The same document indicated staff called the supervisor and the supervisor was able to talk R1 into returning to the facility. R1's progress notes between April 2, 2026, and May 22, 2026, indicated R1 had left the facility nine days, some of those days R1 left the facility more than one time. The progress notes indicated staff had to find R1 and redirect them back to the facility. During an observation on August 31, 2026, at 10:40 a.m., R1 went down the step and exited the front door. The staff member went out the door after R1 but R1 was already out of sight. The staff member came back into the facility to get her car keys. The staff member had to drive down the road to pick R1 up and return him to the facility. During an interview on August 31, 2026, at 11:00 a.m., R1 stated he felt like a prisoner and couldn't go anywhere. R1 stated they keep mini locks on the doors which staff have a key to open. R1 stated other residents must have staff open the door when they want to go outside. R1 stated the locks are not on the door right now because I [the investigator] was there. During an interview, R2 stated the staff put locks	02370			

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02370	Continued From page 9 on the inside door handle, a round lock with a key. R2 stated he had a key to unlock the lock and showed this writer the key. R2 stated prior to this door handle lock they had two metal locks on the garage door. During an interview, the Housing Manager (HM)-A stated R1 constantly tried to leave the facility multiple times a day and doesn't know his way back once he walks away. HM-A stated staff had put a couch in front of the stairway to prevent R1 from leaving the facility, but they quit doing that. HM-A stated staff sometimes use a lock on the door which has a key to open. HM-A stated residents need to be let out of the facility by staff when the lock is on the door. The licensee-provided "Minnesota Assisted Living Bill of Rights" undated, indicated residents have the right to enter and leave the facility as they choose. The right may be restricted only as allowed by other law and consistent with a resident' service plan. TIME PERIOD FOR CORRECTION: Immediately	02370			