Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356125542M
Compliance #: HL356123001C

Date Concluded: December 11, 2025

Name, Address, and County of Licensee Investigated:
Alliance Homes Corporation
7345 74th Way North
Brooklyn Park, MN 55428
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, 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: The facility neglected the resident when it failed to supervise the resident. The resident was found deceased in bed.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. An unlicensed caregiver found the resident unresponsive during the safety check and called 911. The caregiver witnessed the resident's activity had been per his usual earlier in the day.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, death record, hospital records, law enforcement report, related facility policy and procedures. Also, the investigator observed staff and current resident interactions during a recent visit to the facility.

The resident resided in an assisted living facility. The resident's diagnoses included paranoid schizophrenia, anxiety disorder, auditory hallucinations and depression. The resident's service plan included assistance with medication management, assistance with arranging transportation and reminders with personal care. The service plan also indicated aggression management which required de-escalation techniques, identifying underlying triggers and promoting a safe and supportive environment. The services included safety checks three times per day.

The resident's assessment indicated the resident was independent with mobility and used a bicycle for some travel. The assessment did not indicate any cognitive impairment.

A police report indicated police were dispatched for a resident who was down and needed cardio-pulmonary resuscitation (CPR). CPR was initiated however, the resident was declared deceased at the scene. The police report indicated there was evidence of drug paraphernalia at the scene. The report indicated a caregiver and a resident who were in the home were interviewed and reported the resident appeared his usual without impairment earlier that day.

During an interview, the caregiver stated the resident had a typical morning and then left the house on his bicycle. The caregiver stated she did not hear the resident return. She completed a safety check on the resident around 4:00 p.m., found him unresponsive and called 911. The caregiver stated the resident was known to sometimes smoke in his room, but she had no knowledge of any illicit drug use.

During an interview, a nurse stated that illegal drugs are not allowed in the house. The nurse stated caregivers are trained to recognize the behaviors which they may exhibit when under the influence and to notify the nurse right away so she can make an assessment. The nurse stated she did not have concerns on how staff responded the day of the resident's death.

During interview, the director stated the resident had a remote history of drug use but there was no signs of drug use since his admission to the facility.

The death report listed the cause of death as combined cocaine and fentanyl toxicity and accident as the manner of death.

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: No, the resident was deceased.
Family/Responsible Party interviewed: No. Unable to reach for interview.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: No action taken.

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
	35612	A. BUILDING: _____ B. WING _____	C 10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE HOMES CORPORATION	7345 74TH WAY NORTH BROOKLYN PARK, MN 55428

(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 October 23, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL356123001C/#HL356125542M. No correction orders are issued.	0 000		