Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL371855962M
Compliance #: HL371854120C

Date Concluded: January 15, 2026

Name, Address, and County of Licensee Investigated:
Fortunate Homes LLC
6937 France Avenue North
Brooklyn Center, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Jennifer Segal 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 neglected the resident when facility staff failed to respond promptly when the resident left the facility alone for a walk and did not return. The resident was found dead 29 hours later in the facility's backyard.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident had a history of elopement and poor safety judgment. When the resident had an improvement in his health, was physically able to leave the facility and wanted to walk outside multiple times daily, the facility failed to follow the resident's required supervision while outside as care planned by the facility and case manager. The facility continued to allow the resident to walk outside, away from the facility unattended. Additionally, the facility did not follow its protocol for handling missing residents, resulting in a delay that left the resident missing for over 29 hours in the backyard.

The investigator conducted interviews with facility staff, including administrative, nursing, and unlicensed staff. The investigator contacted the medical examiner, county case managers, an outside home care agency, and multiple family members. The investigation included a review of the resident facility record and related facility policies, clinic and hospital records, county social service records, and skilled home care records. The investigator reviewed the full investigation by the medical examiner and the police department. The investigator also observed the neighborhood, including the facility's front and backyard, as well as the area the resident frequently walked.

The resident lived in a 4-bedroom assisted living facility in a residential area with a small front yard and a backyard, mostly enclosed by a chain-link fence. The resident’s diagnoses included a traumatic brain injury, neurocognitive disorder with agitation, major depressive disorder, and a history of alcohol use disorder. The resident's service plan included 24/7 supervision, medication administration, behavioral support, and meals. The facility's assessment noted the resident required extensive support, especially in mental health management.

Two months before the resident went missing, a meeting summary indicated the resident, facility staff, and county case managers met for the resident's semiannual meeting. The team discussed improvements in the resident’s mood and cognition, as well as the resident’s desire to be more engaged in the community. The team discussed potential interventions, and the case manager would determine what services might be available to support the resident. The team agreed the resident continued to require 24/7 supervision outside the facility, and the case manager would explore options and coordinate with the resident’s family.

The day of the incident, a report indicated around 2:15 p.m., the resident told a staff member he was going for a walk outside. Approximately three hours later, staff reported the resident had not returned from his usual 30-minute walk and notified management. The management staff initiated a search for the resident, and after six hours had passed since the resident's disappearance, the facility contacted the resident’s family, then the police department. The facility record failed to clearly note if the resident was allowed to leave alone for a 30-minute walk.

A police report indicated at 8:45 p.m., facility staff reported the resident went for his usual 30-minute walk, and it was unusual for him not to return. The police report indicated staff told police the resident had a brain injury and was not safe alone in the community. It was unusual for him not to return after his usual afternoon walk. The report indicated police completed a search of the area, including nearby stores and parks, as well as the areas the resident was known to walk. In addition, police contacted the resident’s family, local jails, and hospitals; however, no additional information was obtained. Police instructed facility staff to notify them immediately if the resident returned to the facility.

The resident’s facility record did not include any further facility actions planned or completed during the search for the resident until the following day.

The following day, around 12:15 p.m., a facility report indicated family members asked what the resident was wearing when he left the facility, as they would include the details in a social media missing person post. Facility management did not review video surveillance until the family inquired. Two hours later, after viewing the footage, management contacted the family to report what the resident was wearing when he was last seen 24 hours earlier. Management indicated after reviewing surveillance footage, it was unclear whether the resident ever left the backyard after he went missing. At 7:15 p.m., management searched the backyard, found the resident lying in the grass unresponsive, and called 911.

A police report indicated officers were dispatched at 7:32 p.m. for an unconscious resident. Officers found the resident was lying in the backyard next to a chain link fence with no signs of life. The resident's body was very cold to the touch and appeared stiff as if rigor mortis had set in (a process that occurs within hours after death when small muscles stiffen and around 12 hours when the entire body stiffens).

The autopsy and medical examiner's final report indicated the resident's cause of death was an accidental drug overdose; however, hypothermia could not be ruled out.

As police continued their investigation, a report indicated they reviewed facility video and saw no sign of the resident leaving the backyard or staff checking the area. Police believed the resident likely went behind the unattached garage, out of the camera's view, and collapsed there. He was not found until 29 hours later. The last confirmed sighting was at 2:15 p.m. the previous day.

Review of the resident's facility record indicated that, over several months and on most days, the resident walked independently outside the house or the "compound" to a nearby park or strip mall and found his way back to the facility. However, facility nursing staff consistently noted the resident required supervision when outside the facility.

During an interview, facility staff reported the resident was doing well and becoming more independent. The resident was looking forward to a family visit planned for the day he went missing and a family gathering the day afterwards.

During an interview, a facility nurse reported they immediately began a search for the resident and followed their policy. They were surprised and saddened to learn the resident's cause of death and stated the resident showed no signs of substance use.

During an interview, a facility manager stated that if a person were standing in the facility's kitchen, they could see the backyard, except for one small blind spot. In addition, management stated that the resident had no rights restrictions, and he could sign himself out of the facility.

During an interview, a case manager stated the facility was contracted to provide 24/7 care and supervision, and the resident was not authorized to leave the facility on his own without staff or

family. The resident's interdisciplinary team reviewed the plan two months before the resident was found in the backyard. During the meeting, the team agreed that the resident was not safe to be in the community alone and required staff supervision. The facility did not notify the case manager that the resident was missing and deceased until one week later.

During an interview, a family member reported the resident had a history of eloping from the facility, and the police were previously involved. The family indicated the resident was not authorized to be alone in the community. The family member stated that if the staff had responded or looked in the backyard, he could have had Narcan if it were an overdose, and if they had responded sooner, hypothermia would not have been an issue, and he might still be here.

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: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility reported searching the surrounding area and following its policy for a missing resident. Following the incident, the facility provided retraining on missing residents and updated the missing resident policy. In addition, the facility offered grief counseling to staff members.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37185	A. BUILDING: _____ B. WING _____	C 11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORTUNATE HOMES LLC	6937 FRANCE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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: #HL371854120C/#HL371855962M Novemeber 12, 2025, 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 order is issued/orders are issued for ##HL371854120C/#HL371855962M, tag identification 2360.	0 000		
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.	02360		

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02360	Continued From page 1 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		