Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL369731481M
Compliance #: HL369732304C

Date Concluded: July 28, 2025

Name, Address, and County of Licensee Investigated:
New Hope Care
7949 Orchard Avenue North
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Yolanda Dawson, RN
Special Investigator

Finding: Inconclusive

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 a resident when he was not supervised while out in the community.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. There was not a preponderance of evidence that neglect of supervision did or did not occur. At the time of the complaint the resident was allowed 30 minutes in the community without supervision. The resident took that opportunity to walk away from the facility. While no harm came to the resident, leaving the facility for greater than 30 minutes at a time was a violation of the resident's probation and the resident was incarcerated.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case worker. The investigation included review of resident and employee records, facility policy and procedures, text messages and emails to and from the caseworker and guardian.

The resident resided in an assisted living facility. The resident's diagnoses included major depression, bipolar disorder, anoxic brain injury (brain injury from low oxygen), autism, and antisocial personality disorder. The resident's service plan included assistance with behavior monitoring, medication management, and safety checks. The resident's assessment indicated the resident was an elopement risk and staff were directed to report an elopement to the care team and law enforcement.

The facility manager provided text messages to and from the guardian beginning July 2024 through April 2025 regarding the resident's repeated behaviors of leaving the facility and not returning, shutting off his cell phone, and the need for intervention.

During an interview, the guardian stated that the 30-minute alone time was never properly enforced by facility staff, and the resident would leave the facility for long periods of time without notification to the guardian.

During an interview, a facility manager stated at one time the resident had a one-to-one staff member until his behavior improved and he was allowed 30 minutes of alone time outside of the house daily. The manager stated the facility was in constant contact through email with the guardian, case manager. The facility manager stated when the resident failed to return to the facility, a missing person report was filed with the police.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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, incarcerated.
Family/Responsible Party interviewed: Yes, guardian.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility decided this facility was not the proper placement for this resident and provided a warning and a termination notice of services.

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
	36973	A. BUILDING: _____ B. WING _____	C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE CARE LLC	7949 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 On June 5, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL369732304C/#HL369731481M. No correction orders are issued.	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.	