Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL419402783M
Compliance #: HL419401119C

Date Concluded: August 27, 2026

Name, Address, and County of Licensee Investigated:
Forthright Home Care
6818 Toledo Ave N
Brooklyn Center, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, RN, BSN, Special Investigator

Finding: Substantiated, individual 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 alleged perpetrator (AP), a facility staff member, neglected the resident when the AP was found sleeping and failed to provide services to the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP failed to provide supervision of the resident when the AP was found sleeping on the couch at the facility while the resident was in need of assistance.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the case worker. The investigation included review of the resident records, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed staff interactions with a resident.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes, and low extremity weakness. The resident's service plan included assistance with dressing, behavior management, toileting, transfers, daily housekeeping, daily garbage removal, and meal assistance. The resident's assessment indicated the resident was alert, oriented and used a power wheelchair for mobility. The resident's assessment indicated the resident was at risk for abuse.

A law enforcement report indicated police officers responded to a call to the facility by the resident reporting he was trying to get services from the AP, but he was ignoring the resident. When the police arrived, they knocked on the door with no response from the AP. The police knocked for several minutes and looked into the living room window and observed the AP covered in blankets and sleeping. The police knocked harder and woke the AP up and the AP opened the door. The police went to the resident's room, and the resident stated his padded sheet was soiled of urine, he needed juice and requested the garbage to be taken out after the sheet were changed. The law enforcement report indicated the AP would not provide services to the resident because the resident had made verbal threats to the AP. The police officer then advised the AP to provide the services that the resident was requesting. The police officers stayed throughout the duration of the services to ensure the services that the resident requested were completed. In addition, a police officer offered the resident to be taken to the hospital because the resident voiced concerns about infection to his chest wound, but the resident declined.

Law enforcement body camera footage revealed law enforcement arrived at the facility and walked up to the front door that is to the right of a window of the facility. The officer pressed the doorbell and knocked on the door. After several seconds go by, the officer pressed the doorbell and knocked for a second time. After several seconds, the officer knocked for a third time. The body camera footage revealed after the officer knocked; he then looked into the window. The officer then goes back to the door and knocked for a fourth time. The body camera revealed a second officer, and an officer can be heard, he's completely covered in blankets. The officer knocked a fifth time and pressed the doorbell. After several seconds, the officer identified himself as police department and knocked a sixth time. The officer then walked to the right side of the facility towards a ramp that led to a side door of the facility. The officer told the AP that the resident called looking for help. After being outside of the facility for approximately three minutes, the officers entered the facility and went to the resident's room. The body camera footage revealed the resident was in bed watching television, and told the officer, the AP is out there sleeping, and that the resident could hear the AP snoring. The resident then repeated that the AP is asleep and snoring, and that he had been asking for cares to be completed. The resident then stated he needed his padded sheet to be changed, something to drink, and for the heat to be turned down. The resident then stated staff sleep here all the time. After the officer spoke with the resident, the officer went to the living room of the facility, where there was a "L" shaped couch with a pillow and a blanket on the couch. The officer spoke with the AP and after several minutes the AP applied gloves and went into the resident's room to complete cares. The body camera footage revealed the AP removed a new

padded sheet from end of the resident's bed. The resident then rolled to his right side, and the AP positioned the new padded sheet under the resident. The AP then removed the soiled padded sheet and threw it away in the trash can in the resident's room. The officers then told the AP that the resident wanted his cup to be filled. Without washing his hands, the AP continued to wear the gloves that he removed the soiled padded sheet from under the resident and grabbed the resident's cup. The body camera footage revealed the AP asked the resident if he wanted water, and the resident can be heard, not with your gloves on that just touched my butt. The AP then stated I did not touch your butt. The resident can be heard saying yes, you did, then you picked that up, while pointing to the soiled padded sheet in the trash and said, that's dirty and you are going to use the same gloves. The AP denied he touched the soiled padded sheet, the resident then became upset and asked the AP what do you mean you did not touch it. The AP then removed his gloves and asked the resident if he wanted water or juice. The body camera footage revealed the officer told the AP to wash the cup and that he was there to watch services be completed for the resident. The AP took the cup from the resident's room. Then the resident indicated he had been asking for services for two hours and could not walk and that the AP had been asleep. After several minutes, the officer indicated he heard water running and that the resident's cup was cleaned. The AP then came back to the resident's room with the cup full of juice and removed the resident's trash. The body camera footage revealed law enforcement was at the facility for approximately 28 minutes.

The resident's service delivery record was requested but not received. The facility lacked documentation the evening of the incident that indicated the resident refused services.

During an interview, the AP stated when staff offered to complete the resident's services, the resident would refuse services and become verbally and physically abusive to staff. The AP stated the resident's case manager and family member was updated on the resident's behaviors. The resident refused to allow staff to care for the resident's chest wound. The AP denied being asleep when law enforcement arrived the evening of the incident.

During an interview, the case worker stated the resident was given a termination of services notice because of safety concerns. The resident moved out prior to the end date of services being terminated.

A family member declined to be interviewed.

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. Attempted but could not reach.
Family/Responsible Party interviewed: No. The family member declined to interview.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility terminated services with the resident because of safety concerns and updated the case worker.

Action taken by the Minnesota Department of Health:
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
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41940	A. BUILDING: _____ B. WING _____	C 07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORTHRIGHT HOME CARE LLC	6818 TOLEDO AVE N 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, 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: #HL419403004M / #HL419401662C #HL419402783M / #HL419401119C On July 29, 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 was 1 resident receiving services under the provider's Assisted Living license. The following correction order is issued for #HL419402783M / #HL419401119C, tag identification 470 and 2360.	0 000	Assisted Living Provider 144G. 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.	

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0 470	Continued From page 1	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that one person who is responsible for responding to the requests of residents for assistance with health or safety needs was awake at night for one of one resident (R1).	0 470		

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0 470	Continued From page 2 This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), 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). The findings include: R1's service plan dated February 17, 2026, indicated R1 admitted to the facility on March 21, 2026. The service plan indicated R1 required assistance from staff for walking, dressing, behavior management, garbage removal, toileting, and transfers. A law enforcement report dated March 31, 2026, indicated R1 called law enforcement because R1 was attempting to get services from staff. Upon arrival law enforcement knocked at the door for several minutes with no response from the licensee staff. Registered nurse (RN)-A was observed through a window covered in blankets and sleeping. Law enforcement continued to knock harder until RN-A woke up and answered the door. The law enforcement report indicated R1 requested his soiled chuck pad (a single-use, absorbent waterproof sheet designed to protect mattresses and chairs) be changed, more juice to drink and his trash to be taken out. Law enforcement body camera footage revealed law enforcement arrived at the licensee on March 31, 2026, at 9:40pm. The body camera footage revealed an officer walking up to the front door that is to the right of a window of the licensee and pressing the doorbell and knocking on the door.	0 470		

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0 470	Continued From page 3 After several seconds go by, the officer presses the doorbell and knocks for a second time. After several seconds, the officer knocks for a third time. The body camera footage revealed after the officer knocked; he then looked into the window. The officer then goes back to the door and knocks for a fourth time. The body camera revealed a second officer, and an officer can be heard, he's completely covered in blankets. The officer knocks a fifth time and presses the doorbell. After several seconds, the officer identifies himself as police department and knocks for a sixth time. The officer then walked to the right side of the licensee towards a ramp that leads to a side door of the licensee. The officer told RN-A that R1 called looking for help. After being outside of the licensee for approximately three minutes, the officers enter the licensee and go to R1's room. The body camera footage revealed R1 was in bed watching television, and told the officer, RN-A is out there sleeping, and that R1 could hear RN-A snoring. R1 then repeated that RN-A is asleep and snoring, and that he had been asking for cares to be completed. R1 stated he needed his chuck pad changed, something to drink and for the heat to be turned down. R1 then stated staff sleep here all the time. After the officer spoke with R1, the officer goes to the living room of the licensee, where there is a "L" shaped couch with a pillow and a blanket on the couch. The officer spoke with RN-A and after several minutes RN-A applied gloves and went into R1's room to complete cares. The body camera footage revealed RN-A removed a new chuck pad from end of R1's bed. R1 rolled to his right side, and RN-A positioned the new chuck pad under R1. RN-A then removed the old chuck pad and threw it away in the trash can in R1's room. The officers then tells RN-A that R1 wanted his cup to be	0 470		

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0 470	Continued From page 4 filled. Without washing his hands, RN-A continued to wear the gloves that he removed the soiled chucked pad from under R1 and grabbed R1's cup. The body camera footage revealed RN-A asked R1 if he wanted water, and R1 can be heard, not with your gloves on that just touched my butt. RN-A stated I did not touch your butt. R1 can be heard saying yes, you did, then you picked that up, while pointing to the soiled chuck pad in the trash and said, that's dirty and you are going to use the same gloves. RN-A denied he touched the chuck pad, R1 became upset and asked RN-A what do you mean you did not touch it. RN-A then removed his gloves and asked R1 if he wanted water or juice. The body camera footage revealed the officer told RN-A to wash the cup and that he was there to watch services be completed for R1. RN-A took the cup from R1's room. Then R1 indicated he had been asking for services for two hours and could not walk and that RN-A had been asleep. After several minutes, the officer indicated he heard water running and that R1's cup was cleaned. RN-A then came back to R1's room with the cup full of juice and removed R1's trash. The body camera footage revealed law enforcement was at the licensee for approximately 28 minutes. During an interview, on July 29, 2026, at 9:50 a.m., RN-A stated staff are not to be sleeping during their shift and denied that law enforcement found him sleeping. RN-A stated he worked another job besides being a nurse at the licensee. The licensee's policy titled Staff Awake dated March 8, 2026, indicated staff are not to be sleeping, napping or otherwise asleep while on duty during any scheduled night shift unless expressly authorized by the licensee in writing for a specific resident assignment or care plan.	0 470		

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0 470	Continued From page 5 No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470		
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 (R1) reviewed was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		