

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:**  
**Compliance #:**

**Date Concluded:**

**Name, Address, and County of Licensee**

**Investigated:**

Ultimate Care Assisted Living  
3609 78<sup>th</sup> Avenue North  
Brooklyn Park, MN 55443  
Hennepin County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Barbara Axness, RN  
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 it failed to provide adequate supervision after the resident's call light quit working. The resident fell and was unable to call for help. The resident was on the floor yelling for help for three hours until a staff member came to help.

The facility neglected the resident when it failed to provide adequate supervision after the resident eloped from the facility and refused to come back, thinking someone was trying to kill her. The resident was sent to the emergency room and the facility refused to allow the resident to return.

The facility neglected the resident when it failed to ensure medications and treatments were administered as ordered. Staff did not check the resident's blood sugar before administering insulin on multiple occasions and staff failed to ensure the resident's oxygen tanks were refilled in a timely manner.

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect related to administering insulin without checking blood sugar was substantiated. The resident ran out of test strips to check her blood sugar and missed a total of 31 scheduled blood sugar checks over eight days. The resident was still given her scheduled insulin despite staff not knowing what her blood sugar levels were. The registered nurse (RN) was aware the test strips were out and that staff were not checking a blood sugar prior to administering insulin and failed to take immediate action. Several days after being notified of the issue, the facility bought over the counter test strips to check the resident's blood sugar. The RN failed to notify the resident's provider of the issue and failed to complete medication error reports for the instances when insulin was given without checking a blood sugar first.

Neglect related to the facility's management of the resident's oxygen and call light was inconclusive. There was not a preponderance of evidence that staff did not provide necessary cares or services related to the resident's oxygen orders or the resident's call light. There were conflicting reports regarding the resident's care and services received and the facility did not have documentation necessary to support their actions. The facility did not take the resident back after she was sent to the hospital after experiencing a mental health crisis. The resident spent 32 days in the hospital awaiting alternative placement. However, the resident voiced multiple times she did not want to return to the facility. The facility did fail to issue an Emergency Relocation notice when the resident was admitted to the hospital and did not return within four days.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the case manager. The investigation included review of hospital records, facility records including assessments, the service plan, progress notes, and incident reports, and police reports. Also, the investigator observed the resident's room in the facility and care and services at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included bipolar disorder, type two diabetes, and chronic obstructive pulmonary disorder (COPD). The resident's service plan included assistance with dressing, grooming, bathing, medication administration, and used a hoist [mechanical lift] lift for transfers. The resident's record lacked a medication management plan. The resident's assessment indicated facility staff were responsible for managing the resident's medications.

The resident's medication administration record (MAR) contained an order for staff to check the resident's blood sugar levels four times per day, before meals and before bed. The MAR lacked parameters on when staff should call the provider or RN or when insulin should not be given. The MAR contained an order for insulin glargine (a long-acting insulin to manage type two diabetes), take ten units every night.

The resident's Resident Treatment Service Log indicated the resident's blood sugar was to be checked four times per day. The Treatment Service Log indicated the resident's blood sugar was not checked at all on seven consecutive days, and only once on the eighth day. The resident missed a total 31 scheduled blood sugar checks over eight days, yet still was given her insulin.

The resident's blood glucose log included four columns for staff to document the resident's 10:00 a.m., 1:00 p.m., 5:00 p.m., and 10:00 p.m. blood sugar readings. Seven days had "waiting for strips" written in the columns.

The resident's progress notes included progress notes from unlicensed personnel (ULP) documenting that insulin was given on two days. The resident's progress notes lacked any documentation from the RN on communication with the provider or action taken after she was made aware the test strips ran out.

The resident's record lacked medication error reports for the days the resident was given insulin without checking blood sugar first.

The facility's clinical nurse supervisor (CNS), a registered nurse, confirmed the resident ran out of test strips and went several days without having her blood sugar checked before insulin was administered. The CNS stated she was not aware for the first few days and when she was notified, she reached out to the provider's office to try get a new order. The CNS stated the order was obtained but she wasn't aware the pharmacy it was sent to was not able to fill diabetic supplies and she was not notified they were not able to fill it. The CNS stated a few days later, they realized they could get the test strips over the counter so someone from the facility went out to purchase them. The CNS stated she did not initiate any internal investigation or complete any medication error forms related to staff failing to immediately notify her test strips had run out or that staff continued to administer insulin despite not knowing the resident's blood sugar level.

The licensed assisted living director (LALD) confirmed the resident had missed several days of scheduled blood sugar checks due to the pharmacy needing a new order for test strips. The LALD stated he was not aware the resident had missed so many days of blood sugar checks and when the RN had told him they were out, he went out to pharmacy and bought some test strips over the counter. The LALD stated he was not sure if the provider had been updated on the missed blood sugar checks but since the RN had been communicating with the provider's office about obtaining an order for the test strips, they were aware they didn't have any.

The resident's power of attorney (POA) stated, "That place should be shut down." The POA stated they had numerous issues with the facility and she would frequently call the LALD and ask him "what the hell is going on out there." The POA stated the LALD would reassure her he'd take care of any issues. The POA stated she was never notified of any issues with the resident's insulin or test strips but "it wouldn't surprise me one bit" if the resident's blood sugar was not checked prior to receiving insulin.

Manufacturer guidelines for insulin glargine indicated the medication should not be used if blood sugar levels are low.

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:** Attempted

**Family/Responsible Party interviewed:** Yes

**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 Board of Nursing

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/08/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ULTIMATE CARE ASSISTED LIVING - BROOKDALE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3609 78TH AVENUE NORTH BROOKLYN PARK, MN 55443</b>
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(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
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p><b>#HL343577004M/#HL343573312C</b></p> <p>On February 8, 2024, 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 three residents receiving services under the provider's Assisted Living license.</p> <p>The following correction orders are issued for <b>#HL343577004M/#HL343573312C</b>, tag identification 1060, 2310, 2360.</p>	0 000	<p>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 License Providers. 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 surveyors' findings is the Time Period for Correction.</p> <p><b>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.</b></p> <p><b>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</b></p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.</p>	
01060 SS=D	<p><b>144G.52 Subd. 9 Emergency relocation</b></p> <p>(a) A facility may remove a resident from the facility in an emergency if necessary due to a</p>	01060		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Minnesota Department of Health

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01060	<p>Continued From page 1</p> <p>resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.</p> <p>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:</p> <p>(1) the reason for the relocation;</p> <p>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;</p> <p>(3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;</p> <p>(4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and</p> <p>(5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.</p> <p>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:</p> <p>(1) the resident, legal representative, and designated representative;</p> <p>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and</p> <p>(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.</p> <p>(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process</p>	01060		

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01060	<p>Continued From page 2</p> <p>in this section.currently known; and</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one or one resident (R1).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1's diagnoses included bipolar disorder, type two diabetes, and chronic obstructive pulmonary disorder (COPD).</p> <p>R1's service plan dated August 2, 2021, indicated the resident received assistance with dressing, grooming, bathing, medication administration, and used a hoyer [mechanical lift] lift for transfers.</p> <p>R1's progress notes indicated on July 11, 2023, the resident "ran away into the street and call 911 her self saying she wanted to go to the hospital. When the police officer were talking to her she ran away again running with her chair everywhere so the police officer follow her for 4 hours trying to make her come home so they left when she</p>	01060		

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01060	<p>Continued From page 3</p> <p>refused to come home...when 911 came she refused to come in the house so after trying for an hour staff had to bring the hooyer lift in the street before she was able to go to the hospital... (sic)." A progress note entered on July 13, 2023, indicated the resident "has been disruptive, mean to others, hurtful to herself and feared hurtful to others. Not welcome back for safety of other residents."</p> <p>Hospital records indicated R1 was admitted to the hospital on August 1, 2023, after having "a conflict at group home."</p> <p>R1's record lacked a written notice that contained, at a minimum:</p> <ul style="list-style-type: none"> <li>- the reason for the relocation;</li> <li>- the name and contact information for the location to which the resident has been relocated and any new service provider;</li> <li>- contact information for the Office of Ombudsman for Long-Term Care;</li> <li>- if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known;</li> <li>- a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.</li> </ul> <p>In addition, R1's record lacked notification to the Office of Ombudsman for Long-Term Care with in four days that R3 had been relocated and had not returned to the facility.</p> <p>On February 12, 2024, at 8:40 a.m., licensed assisted living director (LALD)-A stated he had</p>	01060		

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01060	<p>Continued From page 4</p> <p>been in touch with the resident's sister but confirmed he had not sent an emergency relocation notice.</p> <p>On February 12, 2024, at 9:45 a.m., R1's power of attorney (POA)-XX stated LALD-A had refused to let R1 return to the facility and they had not been given any notices or information on their rights related to emergency relocations. POA-XX stated she told LALD-A "You cant legally do this and he said, "well she's been a problem and we can't control her and she needs some different medication because she ain't right and she needs too much attention and too much care." I wish I would have recorded it, he was a real jackass."</p> <p>No further information was provided.</p> <p>TIME PERIOD TO CORRECT: Twenty-one (21) days.</p>	01060		
02310 SS=G	<p><b>144G.91 Subd. 4 (a) Appropriate care and services</b></p> <p>(a) 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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide appropriate care, services, and supervision for one of one residents (R1) with four times per day blood sugar checks and orders for insulin. The resident ran out of test strips to check her blood sugar and missed a total of 31 scheduled blood sugar checks over eight</p>	02310		

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02310	<p>Continued From page 5</p> <p>days. The resident was still given her scheduled insulin. The registered nurse (RN) failed to notify the resident's provider and failed to complete medication error reports for the instances when insulin was given without checking a blood sugar first. In addition, the licensee failed to provide appropriate care, services, and supervision for one of one residents (R1) with wounds. The resident admitted to the hospital with two wounds. R1's record lacked any documentation of one wound or that the registered nurse (RN) was aware of the wounds.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>Findings include:</p> <p><b>BLOOD SUGAR CHECKS</b> R1's diagnoses included bipolar disorder, type two diabetes, and chronic obstructive pulmonary disorder (COPD).</p> <p>R1's service plan dated August 2, 2021, indicated the resident received assistance with dressing, grooming, bathing, medication administration, and used a hoyer [mechanical lift] lift for transfers.</p> <p>R1's record lacked a medication management plan and a treatment management plan.</p> <p>R1's medication administration record (MAR)</p>	02310		

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02310	<p>Continued From page 6</p> <p>contained an order for staff to check the resident's blood sugar levels four times per day, before meals and before bed. The MAR lacked parameters on when staff should call the provider or RN or when insulin should not be given. The MAR contained an order for insulin glargine (a long acting insulin to manage type two diabetes), take ten units every night.</p> <p>R1's June 2023 Resident Treatment Service Log indicated the resident's blood sugar was to be checked four times per day. The Treatment Service Log indicated the resident's blood sugar was not checked at all on June 14, June 15, June 16, June 17, June 18, June 19, June 20, and only once on June 21. The resident missed a total 31 scheduled blood sugar checks over eight days, yet still was given her insulin.</p> <p>R1's blood glucose log for June 2023, included four columns for staff to document the resident's 10:00 a.m., 1:00 p.m., 5:00 p.m., and 10:00 p.m. blood sugar readings. June 14, June 15, June 16, June 17, June 18, June 19, and June 20 had "waiting for strips" written in the columns. "Waiting for strips delivery" was written on the 10:00 a.m., 1:00 p.m., and 5:00 p.m. checks. The resident's blood sugar at 10:00 p.m. was 241.</p> <p>R1's progress notes included progress notes from unlicensed personnel (ULP) documenting that insulin was given on June 14 and June 19, 2023. R1's progress notes lacked any documentation from the RN on communication with the provider or action taken after the test strips ran out.</p> <p>R1's record lacked evidence the provider was updated on the missed blood sugar checks and the fact the resident was still given insulin.</p>	02310		

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02310	<p>Continued From page 7</p> <p>R1's record lacked medication error reports for the days the resident was given insulin without checking blood sugar first.</p> <p>On February 12, 2024, at 8:45 a.m., licensed assisted living director (LALD)-A confirmed the resident had missed several days of scheduled blood sugar checks due to the pharmacy needing a new order for test strips. LALD-A stated he was not aware the resident had missed so many days of blood sugar checks and when the RN had told him they were out, he went out to pharmacy and bought some test strips over the counter. LALD-A stated he was not sure if the provider had been updated on the missed blood sugar checks but since the RN had been communicating with the provider's office about obtaining an order for the test strips, they were aware they didn't have any.</p> <p>On February 12, 2024, at 9:45 a.m., R1's power of attorney (POA)-C stated, "That place should be shut down." POA-C stated they had numerous issues with the facility and she would frequently call LALD-A and ask him "what the hell is going on out there." POA-C stated LALD-A would reassure her he'd take care of any issues. POA-C stated she was never notified of any issues with the resident's insulin or test strips but "it wouldn't surprise me one bit" if the resident's blood sugar was not checked prior to receiving insulin.</p> <p>On February 13, 2024, at 10:40 a.m., clinical nurse supervisor (CNS)-B confirmed the resident ran out of test strips and went several days without having her blood sugar checked before insulin was administered. CNS-B stated she was not aware for the first few days and when she was notified, she reached out to the provider's office to try get a new order. CNS-B stated the</p>	02310		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/08/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ULTIMATE CARE ASSISTED LIVING BROOKDA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3609 78TH AVENUE NORTH BROOKLYN PARK, MN 55443</b>
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(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
02310	<p>Continued From page 8</p> <p>order was obtained but she wasn't aware the pharmacy it was sent to was not able to fill diabetic supplies and she was not notified they were not able to fill it. CNS-B stated a few days later, they realized they could get the test strips over the counter so someone from the facility went out to purchase them. CNS-B stated she did not initiate any internal investigation or complete any medication error forms related to staff failing to immediately notify her test strips had run out or that staff continued to administer insulin despite not knowing the resident's blood sugar level.</p> <p>Manufacturer guidelines for insulin glargine, dated July 2015, indicated the medication should not be used if blood sugar levels are low.</p> <p><b>WOUNDS</b> R1's assessment dated June 27, 2023, indicated the resident had a "pressure ulcer, healing, to right upper ankle from brace after casting done for tib/fix fx [tibia and fibula fracture, bones in the lower leg]..."</p> <p>R1's progress notes indicated an antibiotic ointment was prescribed for the resident's foot on June 13, 2023. The nurse "came and dressed [R1's] wound" on June 14, 2023. CNS-B assessed the wound 15 days later on June 29, 2023, and noted "wound care done to right back of heel, filling in nicely, some swelling, no odor, slight redness around it. Bacitracin to adaptic to gauze, wrapped with ace."</p> <p>R1's record lacked any further documentation or monitoring of the pressure ulcer.</p> <p>R1's record lacked a treatment management plan or documentation of wound care provided.</p>	02310		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER  <b>ULTIMATE CARE ASSISTED LIVING BROOKDA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3609 78TH AVENUE NORTH BROOKLYN PARK, MN 55443</b>
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02310	<p>Continued From page 9</p> <p>R1 admitted to the hospital on July 11, 2023, after experiencing a mental health crisis.</p> <p>Wound care notes from the resident's hospital admission on July 11, 2023, indicated the resident arrived at the hospital with two wounds present. One wound was a "chronic appearing" pressure ulcer to her right heel. The other wound was on the back of the resident's right thigh noted to be an "abrasion that is surrounded by scars. Wound appears to be friction/trauma related. Patient states she needs a hoyer for transferring which may be the cause."</p> <p>On February 13, 2024, at 10:40 a.m., CNS-B confirmed she was not aware the resident had a friction related wound. CNS-B stated she would expect staff to notify her of any wounds and while she would do periodic skin checks of residents, she had not noticed the friction wound. CNS-B stated she was aware of the resident's right heel pressure ulcer but confirmed there was no treatment management plan or documentation and monitoring of the pressure ulcer due to limitations with their electronic charting system. CNS-B stated staff should have been documenting any wound care they completed and was not sure why there was not any other documentation.</p> <p>No additional information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	02310		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial</p>	02360		

Minnesota Department of Health

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02360	<p>Continued From page 10</p> <p>exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>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.</p>	02360	No plan of correction is required for this tag.	