STATE LICENSING COMPLIANCE REPORT

Report #: HL364694707C **Date Concluded:** May 25, 2023

Name, Address, and County of Facility Investigated:
Berkeley Heights Homes LLC
1808 Meadowwood Court
Brooklyn Park, MN 55444
Hennepin County

Facility Type: Assisted Living Facility (ALF) **Evaluator's Name:** Barbara Axness, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36469	A. BUILDING: _____ B. WING _____	C 05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOMES LLC	1808 MEADOWWOOD COURT BROOKLYN PARK, MN 55444

(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 LICENSING 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: #HL364694707C On May 15, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were two residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL364694707C, tag identification 1140.	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 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. 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 subd. 1, 2, and 3.	
01140 SS=D	144G.55 Subd. 3 Relocation plan required The facility must prepare a relocation plan to prepare for the move to a new safe location or	01140		

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01140	Continued From page 1 appropriate service provider, as required by this section. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to prepare a relocation plan that included documentation of considerations for the care needs, psychosocial impacts of moving, and accounting of residents property prior to initiating the transfer of one of one residents receiving assisted living services. The resident was discharged and facility staff moved the residents belongings out of the facility without notice after a verbal altercation occurred. 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). The findings include: R1 admitted for services on August 1, 2022, and was discharged on September 2, 2022. R1's diagnoses included borderline personality disorder, major depression, and bipolar disorder. R1's service plan, dated August 1, 2022, indicated the resident received services including medication reminders, behavior monitoring, and reminders for dressing and bathing. R1's August 1, 2022, assessment indicated the	01140		

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01140	Continued From page 2 resident was susceptible to abuse from other individual including other vulnerable adults. The assessment indicated the resident had behavioral symptoms which included withdrawal, isolation, verbal aggression, hostility, pacing, angry outbursts, and cursing and swearing. A September 2, 2022, incident report indicated R1 called another resident a racial slur and then insulted the neighbors and again used a racial slur. The incident report indicated the client went to Wal Mart after the incident and returned around 7:00 p.m. that evening and "almost abused staff physically, staff was about to call the police when the neighbors called the police. The police escorted the client to her new place and staff documented client's behavior." A September 6, 2022, note documented by the resident's case manager, indicated R1 contacted her and shared that over the weekend, she was moved to a new home. The note indicated the resident went out with a friend and when she returned to the facility, she went to her room and noticed her belongings were removed and her cat was no longer there. The case manager documented that R1 "said that staff then told her that she was being moved to a new home and that her choices were to either go along with the move or she could go to jail." The resident reported to the case manager that there was a neighbor gentleman who was outside with his kid and he was bothering [R1]with by being "loud and irresponsible," so[R1] told him to go back inside, and when he would not do so, [R1] told him to "Go back to his country." [R1] said that this upset the man and he ended up calling the cops." On May 15, 2023, at 2:30 p.m., owner (O)-A stated the resident "was beating up staff and	01140		

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01140	Continued From page 3 clients and we discharged her. The ombudsman told us they'd be reporting us. I said we're fine with it at the end of the day, the overall health and safety of the vulnerable adults and our staff, we'll take that over an investigation any day of the week." On May 16, 2023, at 9:35 a.m., licensed assisted living director (LALD)-B stated the resident "had issues with the client and residents there and she was always hitting them and verbally and physically abusing them and she was not compatible so we decided to move her to another home." LALD-B stated they had a couple of care conferences with the resident and a discharge notice was issued but he wasn't sure if the ombudsman was notified." On May 24, 2023, at 2:15 p.m., R1's case manager (CM)-C stated they were not notified by the facility that the resident had been discharged and were only notified when the resident called them four days after she had moved. CM-C stated the resident had been told she had to go along with the move or go to jail. On May 25, 2023, at 11:00 a.m., R1 stated she felt she was unfairly discharged from the facility. R1 stated "I came home and all my stuff was gone, it was moved to another facility in a different city." R1 stated the licensee drove her to the other facility and told her she'd be moving there and she was not given a choice in where she moved to. R1 stated she was very upset and didn't want to move and did not get any advanced notice or written notices about being discharged. On May 25, 2023, at 11:20 a.m., LALD-B confirmed R1 was moved the same day the verbal altercation occurred and had been moved	01140		

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01140	Continued From page 4 to a sister facility. LALD-B stated R1 did not receive any pretermination notices in writing and they had only verbally discussed expectations with the resident. The resident's Resident Agreement contract, signed by R1 on August 1, 2022, contained the following on page 7, section C: Termination by the Facility We may terminate this agreement by providing at least 30 days' advanced written notice to you if you do not timely pay the fees owed to the facility or if you fail to comply with any other term or condition of this Agreement, and such failure continues after we provide you written notice of the failure. In certain cases, we may terminate this Agreement on an expedited basis by providing 15 days' advanced written notice to you. The licensee's Discharge and Transfer of Residents policy, dated August 1, 2021, indicated residents discharged or transferred from Berkeley Heights Homes will have a coordinated process for discharge or transition to another provider/setting. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01140		