

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL366007323M
Compliance #: HL366002462C

Date Concluded: April 21, 2025

Name, Address, and County of Licensee

Investigated:

Suite Living of Brooklyn Park
8500 Regent Avenue North
Brooklyn Park, Minnesota 55443
Hennepin County

Facility Type: Assisted Living Facility with
Dementia Care (ALFDC)

Evaluator's Name: Nicole Myslicki, 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 the facility failed to provide services according to provider orders and the resident's service plan. The resident sustained several bladder infections.

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 urinary tract infections (UTIs). Due to the resident's history her medical provider ordered daily perineum washing after the first UTI for prevention. The facility failed to implement physician orders for daily wash ups to help keep the resident clean for several months. The resident developed three UTI in less than six months.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the physician and law

enforcement. The investigation included review of the resident record, facility incident reports, staff schedules, related facility policy and procedures. Also, the investigator observed toileting and transfer assistance, call light response times, and a meal service.

The resident resided in an assisted living facility. The resident's diagnoses included strokes and urinary incontinence. The resident's service plan included assistance with toileting, perineal care, and showers, as well as medication management. The resident's assessment indicated due to her urinary incontinence, the resident needed help with toileting, including perineal care.

UTI #1

The resident's medical record indicated the provider ordered staff to increase the frequency of bathing with cleansing of the perineum to daily in the mornings. The next day, a progress note in the resident's record indicated the resident displayed confusion and paranoia.

One week later, the provider ordered an antibiotic for 10 days due to the resident being diagnosed with a UTI. A progress note from the same day indicated the resident received an order for the antibiotic for a UTI.

The resident's service delivery record for the month indicated the resident received bathing assistance: a shower utilizing soap and water, washing the resident's body including perineum for 15 of the days. The service delivery record for the month did not include the order for daily bathing with cleansing of the perineum in the mornings.

The resident's service delivery records for the following two months also failed to include the order for daily bathing with cleansing of the perineum in the mornings. The service delivery record from the first month after the resident's UTI, indicated the resident received the same bathing assistance 19 times. The second month after the first UTI, the resident's service delivery record indicated she received the bathing assistance seventeen 17 days. The service delivery record for the month included toileting assistance, indicating the resident required staff assistance with toileting including transferring to and from the toilet, peri-care, and getting her clothing back up. This service started halfway through the month, and staff completed it nearly every shift for the rest of the month.

UTI #2

About three months after the first UTI, the provider ordered an antibiotic for the resident.

The next day, a progress note included the order for an antibiotic for the resident's UTI. The resident's service delivery record for the month indicated the resident received the same bathing assistance as she did prior months 26 days. The service delivery record also included the toileting assistance with peri-care which the resident received daily, nearly every shift.

There were no progress notes around this time identifying concerns or symptoms of a UTI.

UTI #3

At the end of the next month, the resident's provider ordered for a urinalysis due to recurrent UTIs. The next day, a progress note indicated the facility collected a urine sample for the family to pick up and bring to the resident's provider.

Four days later, the resident's provider ordered an antibiotic for 14 days. A progress note the next day indicated the facility received the faxed order from the provider to administer an antibiotic for 14 days.

The resident's service agreement, updated a few weeks prior, indicated the resident received one shower a week. The service agreement did not include daily bathing with cleansing of the perineum in the mornings.

The resident's service delivery record for the month indicated the resident received the same bathing assistance as she did prior months 22 times. The service delivery record also indicated the resident received the toileting assistance with peri-care every day, nearly every shift.

During investigative interviews, several unlicensed personnel (ULP) stated the resident had recently been receiving two showers weekly and daily wash ups with soap and water.

During an interview, a nurse stated the resident had a history of UTIs. Since putting interventions in place, the problem did improve. The facility implemented cleansing the resident with soap and water daily and showers one to two times per week. The nurse stated they did get the written order for daily wash ups but did not know the full timeline between discussing the issue, receiving an order, and implementing. The nurse stated the increase in showers were more of a discussion between nursing and family, while the provider had been pushing more for the wash ups of the perineum.

During an interview, the resident's provider stated the resident had a history of UTIs, going back several years. However, she only had up to one or two in a given year. The resident had an increased risk for UTIs due to her incontinence. The provider originally wrote an order for the resident to be cleaned up daily one month, due to getting a UTI. Then he had to write another order three months later due to the first order not being followed. The facility should have implemented the order as soon as they received them, but it appeared they did not implement them for several months. The provider stated the facility had been doing a better job recently.

During an interview, the resident stated she had a couple of UTIs. One shower a week had not been good enough and needed to shower twice a week. The resident stated facility staff were currently doing a sufficient job at cleaning her up each morning.

During an interview, a family member stated the resident had incontinence, so staff needed to make sure she was properly cleaned. The family member identified the resident as susceptible to UTIs if not kept clean. Previously, the resident's provider wrote orders for the facility to wash

her up daily in the morning because he had been concerned about this. However, the resident had not been getting washed up. The provider also wrote an order for to receive two showers a week, but that did not happen either. The family member stated the resident got a UTI two months in a row and became very sick and confused during that time.

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.

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:

(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;

(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;

(iii) the error is not part of a pattern of errors by the individual;

(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;

(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and

(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The facility did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

(3) The facility failed to follow professional standards and/or exercise professional judgement.

The facility failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: Yes.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility did eventually implement orders to shower the resident twice weekly and wash her up daily.

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: 36600	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/10/2025
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NAME OF PROVIDER OR SUPPLIER SUITE LIVING OF BROOKLYN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 8500 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443
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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>ASSISTED LIVING PROVIDER CORRECTION ORDER</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>HL366002462C/HL366007323M</p> <p>On March 10, 2025, 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 27 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for HL366002462C/HL366007323M, tag identification 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 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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>Residents have the right to be free from physical,</p>	02360		

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

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER SUITE LIVING OF BROOKLYN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 8500 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443
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02360	<p>Continued From page 1</p> <p>sexual, and emotional abuse; neglect; financial 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 resident(s) 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		