Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL368523403M
Compliance #: HL368525467C

Date Concluded: November 16, 2023

Name, Address, and County of Licensee Investigated:
Berkeley Heights Homes LLC
1509 Sugarloaf Trail
Brooklyn Park MN 55444
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela R.N.
Special Investigator

Finding: Not Substantiated

Nature of Visit:
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 staff failed to intervene when the resident was bit, harassed, threatened, and offered alcohol by other residents of the facility. In addition, facility staff failed to administer medications in accordance with physician's orders and failed to provide transportation to medical appointments, causing the resident to experience significant pain.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. There was a lack evidence to support the resident was bit, harassed, threatened, or offered alcohol by other residents. The resident's medical records indicated all medications were administered in accordance with physician's orders and the resident was provided transportation to several physician appointments, including hospital visits, related to pain.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of facility documentation, resident medical records, employee personnel records, training records, and facility policies and procedures. Also, the investigator observed medication and treatment administration and staff interaction with residents at the time of the onsite visit.

The resident resided in an assisted living facility with diagnoses which included borderline personality disorder, anxiety, and depression. The resident's service plan included assistance with medication administration and daily safety checks. The resident's nursing assessment included a history of mood disorder including paranoid delusions and hallucinations.

Facility documentation reviewed included no evidence of incidents or reports of the resident being harassed or threatened by staff or being offered alcohol by other residents.

According to the resident's medication administration record (MAR) all medications were administered in accordance with physician's orders. The resident had frequent leaves of absence (LOA) from the facility. Nursing staff communicated with the resident's physician to allow for medication set-up for LOAs, to decrease the resident's travel back and forth to the facility to pick-up medications. However, orders to release medications to the resident were later discontinued due to safety concerns with the release of narcotic medications.

The resident's medical records indicated the resident experienced back pain six times over an eight-month period. The resident arranged transportation to the hospital on four occasions, and on some occasions, declined PRN (as-needed) pain medications, canceled, or refused to attend scheduled appointments with the physician and/or physical therapy.

The resident's medical records identified a physical altercation occurred with another resident over money. During the altercation, the resident sustained a scratch on his left hand and a bruise under his left elbow but did not report he had been bit. Staff intervened and assessed the residents for injuries.

During an interview, nursing and administrative staff reported they were not aware of any threatening or harassing behavior expressed towards the resident. Nursing staff denied medication errors and were not aware of any incident where inaccurate medications were administered to the resident. Nursing staff stated the resident's medications were set-up regularly by a licensed nurse for his frequent LOAs from the facility. Nursing and administrative staff stated the resident was provided transportation to all scheduled physician appointments including the appointments he cancelled or refused to attend.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act

meeting the definition of maltreatment 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, attempts to contact were unsuccessful.
Family Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
None.

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
	36852	A. BUILDING: _____ B. WING _____	C 08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOMES LLC	1509 SUGARLOAF TRAIL 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 On August 22, 2023, the Minnesota Department of Health initiated an investigation of complaints #HL368523403M/HL368525467C, #HL368524244M/HL368527180C, #HL368527885M/HL368524776C, #HL368527886M/HL368524777C. No correction orders are issued.	0 000		