DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL368526483M
Compliance #: HL368529666C

Date Concluded: December 31, 2024

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

Facility Type: Assisted Living Facility (ALF)

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

Finding: Not Substantiated

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 supervision and interventions to ensure the resident and other resident's safety. In addition, the facility discontinued the resident's medications without a physician order.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Facility staff provided the resident with supervision according to the resident's assessed needs and plan of care. The facility staff provided the resident her anti-psychotic medication, Vraylar, for mood control as the resident allowed. Facility staff discontinued the resident's other medications including insulin, Lasix (treats fluid retention), and Atorvastatin (treat high cholesterol) due to the resident's non-compliance, without a provider order however, the discontinuation resulted in a licensing order and did not rise to the level of maltreatment.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's case manager and mental health case manager. The investigation included review of the resident records, hospital records, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed staff interactions with residents at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included bipolar disorder, borderline personality disorder, schizophrenia, post-traumatic stress disorder, anxiety, visual hallucinations, and auditory hallucinations. The resident's service plan included assistance with medication management and safety checks. The resident's assessment indicated the resident was independent with transferring and walking and could leave the facility independently after notifying staff. The resident had a history of refusing cares and medications.

The hospital record indicated one day; during a psychiatric clinic visit the provider discussed with the resident the benefit of a long-acting injectable antipsychotic medication along with a higher dose of an oral antipsychotic medication due to the resident's history of non-compliance with medications. However, the resident only agreed to continue with her current antipsychotic medication, Vraylar. The hospital record indicated the resident did not fully understand her mental health, and the resident's medication compliance had been difficult. At the time of the visit, the resident did not qualify for hospitalization because she was not a danger to herself or others.

The records indicated the evening after the psychiatric visit the resident was agitated. The resident came into the kitchen area of the facility and got into a verbal altercation with another resident. The verbal altercation led to a physical altercation. The resident hit resident with a fire extinguisher. Facility staff attempted to intervene, called the police, and called COPE (a mobile crisis response team). The police de-escalated the situation and both residents went to their rooms.

Following the incident with the other resident, the resident spent the next three days in her room with safety checks provided by facility staff every shift. On the fourth day, a team meeting was scheduled that included the resident, resident's case worker, resident's mental health worker, and facility leadership. Prior to the team meeting that day, the resident left the facility without notifying facility staff. During the team meeting it was determined when the resident returned to the facility, the resident would be transferred to the hospital for a psychiatric evaluation. That evening when the resident returned to the facility, COPE was notified, and the resident was transferred to the hospital.

The hospital record indicated the resident was admitted due to a sudden onset of psychotic symptoms. Initially the resident was placed on a 72 hour hold for an evaluation. While hospitalized the resident actively experienced perceptual disturbances (can involve seeing,

hearing, feeling, tasting, or smelling things that aren't there) and delusional ideation (fixed false beliefs that are not based in reality) and was hospitalized for 44 days.

During an interview, a facility nurse stated the resident was independent with activities of daily living. The resident walked and at times the resident would let us know where she was going if she left the facility and at what time she planned on being back to the facility. Just prior to the scheduled team meeting, the resident left the facility without notifying staff and returned to the facility a few hours later. When the resident returned to the facility, facility staff contacted COPE, and the resident was transported to the hospital.

During an interview, nursing leadership stated the resident often cancelled or walked out of her doctor appointments. Once the resident was hospitalized, all the resident's medications were reordered, and a commitment was completed for the resident. With the commitment, if the resident becomes non-compliant with antipsychotic medications, the resident can be hospitalized.

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. The resident resided at a different facility.
Family/Responsible Party interviewed: No. The resident was responsible for herself.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility made attempts to have the resident seen her psychiatric doctor. The facility also notified COPE and the police when the resident experienced paranoia and agitation. Once the incident between the resident and the other resident occurred, the facility met with the resident's case managers and the resident was transported to the hospital.

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

Minnesota Department of Health

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 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOMES OF MINNESOTA	**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 December 10, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL368526483M/#HL368529666C. No correction orders are issued.	0 000		

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