Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL368527886M
Compliance #: HL368524777C

Date Concluded: November 16, 2023

Name, Address, and County of Licensee Investigated:
Berkeley Heights Home 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 resident when the resident was found starting a fire in the garage and eloped from the facility on several occasions.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident left the facility on multiple occasions, the resident was allowed independence in the community. It was unable to be determined if the resident started a fire in the garage.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's case manager. The investigation included review of the resident's medical records, personnel records, and facility policies and procedures. At the time of the onsite visit, the investigator observed staff interactions with residents and medication and treatment administration.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia, borderline personality disorder, bipolar disorder, and hallucinations. The resident's service plan included assistance with housekeeping, laundry, daily behavioral monitoring, and safety checks. The resident's assessment indicated the resident had a history of anxiety, depression, psychosis, and delusions.

The resident's medical record included an incident where staff found the resident in the garage near a pile of dried sticks, leaves, and ash. There was no evidence of the resident starting a fire.

Further review of the resident's medical record identified multiple occasions of the resident leaving the facility and returning hours later. However, the resident's county assessment and community support plan indicated the resident had a job and was allowed independence in the community.

During an interview, the resident stated she was independent and could leave the facility if she felt it was safe. The resident stated staff liked to know where she was going when she left, but staff did not enforce her usage of the facility sign-in/sign-out book. The resident indicated she did not start a fire at the facility, but recalled an incident where staff found her burning sage in the garage.

During an interview, the resident's case worker indicated she was not aware of any elopements or fires started by the resident during the resident's stay at the facility.

During an interview, facility management staff did not recall the incident in the garage or staff questioning the resident about starting a fire. Facility management staff indicated they did not identify the resident as an elopement risk. Management staff stated the resident was informed to sign out prior to leaving the facility and there were interventions in place should the resident leave the facility without notification.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
None.

Action taken by the Minnesota Department of Health:
No action taken.

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		