STATE LICENSING COMPLIANCE REPORT

Report #: HL373623780C

Date Concluded: January 8, 2025

Name, Address, and County of Facility Investigated:
Brooklyn Park Assisted Living
7711 Humboldt Avenue North
Brooklyn Park, MN 55444
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, 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
	37362	A. BUILDING: _____ B. WING _____	C 01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKLYN PARK ASSISTED LIVING	7711 HUMBOLDT AVENUE NORTH 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 CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order is 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: #HL373623780C On January 6, and 7, 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 license. The following immediate correction order is issued for #HL373623780C, tag identification 0790.	0 000		
0 790 SS=I	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3	0 790		

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0 790	Continued From page 1 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a safe physical environment for 27 of 27 residents reviewed when the licensee allowed unmonitored/unmaintained space heaters used in resident rooms (one of which tripped a circuit breaker), in the staff office, and one unattended next to a couch in a common area. This had the potential to cause serious injury or death to all residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings Include: R7 admitted to the facility on October 15, 2021, due to diagnoses that included spinal cord injury with resulting quadriplegia. R7's care plan dated October 3, 2024, indicated R7 required the assistance of two staff for transfers with a full mechanical lift. R21 admitted to the facility on January 18, 2022,	0 790		

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0 790	Continued From page 2 due to diagnoses that included multiple sclerosis. R4 admitted to the facility on November 3, 2022, due to diagnoses that included quadriplegia. R4's care plan dated October 16, 2024, indicated R4 required the assistance of two staff for transfers with a full mechanical lift. During an observation on January 6, 2025, at 1:17 p.m. a Minnesota Department of Health (MDH) investigator observed a space heater on and heating R7's room (in building three). The MDH investigator felt the room to be very warm. The MDH investigator also observed multiple items of paper, cardboard, clothing, and curtains within three feet of the space heater. During an observation of building one, on January 7, 2025, from 10:45 a.m. to 12:35 p.m. the MDH investigator heard a smoke detector chirping. During an interview on January 6, 2025, at 11:45 a.m. R4 stated staff did not often change the smoke detector batteries when low. R4 stated the last time it chirped for two months before staff changed it. During an interview on January 7, 2025, at 10:25 a.m., unlicensed personnel (ULP)-A stated the smoke detector made a chirp noise when R21's space heater was on in R21's room and tripped the circuit breaker in that building. ULP-A stated, "It happens all the time, it will eventually reset." During an observation on January 7, 2025, at 10:38 a.m. in building three, the MDH investigator observed an unattended space heater on, within a few inches of a couch and a table in a common area.	0 790		

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0 790	Continued From page 3 During an interview on January 7, 2025, at 10:38 a.m. ULP-B stated a nurse brought the space heater over from the office when she came to building three, set it up, turned it on, and left the area. During an interview on January 8, 2025, at 9:00 a.m., former operations manager (OM)-C stated the licensee did not employ a maintenance person or have a policy for use of space heaters. OM-C stated he observed staff putting space heaters in a bathroom to keep it warm while bathing residents. OM-C stated one fourth to one third of residents had a space heater in their room and staff often placed additional space heaters in the office or common areas while they were working. OM-C stated the licensee always had a strict rule about the thermostat remaining set between 68- and 72-degrees Fahrenheit. OM-C stated he recommended the facility address space heaters as part of the facility emergency preparedness plan but was denied by upper management. A policy for space heater use, management, and maintenance was requested but not provided. TIME PERIOD FOR CORRECTION: Immediate	0 790		