Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL373627522M
Compliance #: HL373627444C

Date Concluded: July 6, 2026

Name, Address, and County of Licensee Investigated:
The Lodges of Brooklyn Park Assisted Living
7711 Humboldt Ave N
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 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 staff did not report, assess or treat the resident's skin causing pressure wounds to both heels.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had a history of refusals of care and treatments. When facility staff discovered the resident's wounds they immediately assessed and treated the wounds and sent the resident to the hospital for further evaluation and treatment. Upon return to the facility, the resident's wounds were treated weekly and one pressure area healed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted acute care staff. The investigation included review of the resident record(s), hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also,

the investigator observed medication administration and wound care and staff interaction with the resident.

The resident resided in an assisted living facility. The resident's diagnoses included multiple sclerosis and peripheral artery disease. The resident's service plan at the time of the incident included assistance with medication management, dressing, bathing, transfers, ambulation with a gait belt and two wheeled walker and use of a manual wheelchair for long distances. The resident's assessment indicated the resident was alert and oriented and independent with making reasonable and consistent decisions. In addition, the resident was independent with bathing and dressing but needed assistance in and out of the shower and dressing the lower extremities. The resident's assessment completed one week prior to the incident indicated the resident reported they had no skin concerns.

The resident's medical records indicated the resident refused showers, refused to remove compression wraps, and refused to lie down in bed and elevate her feet to reduce swelling at night. The resident was also having difficulty bearing weight during transfers.

The resident's medical records indicated the resident had been seen by physical therapy (PT), and occupational therapy (OT), approximately one month prior to the heel wounds being discovered. At that time OT changed the resident's bilateral lower extremity treatments to accommodate the resident's increased edema. The resident's medical records indicated the resident was also not consistently compliant with OT recommendations.

The day before the resident's wounds were reported, the resident's provider assessed the resident and ordered a mechanical lift with assist of two staff for all transfers and a mechanical wheelchair for mobility due to the resident's difficulty with transfers and ambulation.

The resident's medical records indicated a nurse identified, assessed and treated the resident's wound then updated the resident's provider who recommended the resident be transported to the hospital to have the wounds further evaluated.

Facility management initiated an investigation into the wounds. Facility documentation indicated facility staff found and reported a blister on the resident's right heel and a wound on the resident's left heel. Unlicensed staff were interviewed who reported that the resident frequently refused showers and stocking removal, but they did not consistently report the resident's refusals and were not aware of the need to report refusals.

The resident's hospital medical records indicated the resident informed hospital staff that painful wounds started a few months ago and were evaluated by the facility but not treated. Later, the resident informed hospital staff that a provider came to the facility and cared for the resident's heel wounds every two weeks but the provider went on vacation and the resident's wounds became too painful and required hospital evaluation. Before returning back to the facility, the resident was diagnosed with the pressure ulcers and peripheral artery disease

(narrowed arteries reduce blood flow to the limbs, most commonly the legs) and an exacerbation of multiple sclerosis.

The resident's facility medical records indicated when the resident returned to the facility, unlicensed staff reported bathing and care refusals to the nurse, in addition, nursing staff assessed and treated the resident's wounds weekly. Despite the resident continuing with occasional refusal of services, approximately one month later the right heel wound resolved.

During an interview, an administrative nurse stated the resident was admitted with lower left leg edema. The nurse stated the resident had a history of refusing skin assessments and cares and the resident's declines in ambulation, refusals and medications were reviewed by the provider one day prior to the wounds being discovered. The nurse recalled the resident's right heel improved quickly after the resident returned to the facility and treatments were completed as prescribed.

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.
Insert maltreatment definition here.

Vulnerable Adult interviewed: No. The resident did not respond to multiple interview requests.
Family/Responsible Party interviewed: Not Applicable. Resident responsible for self.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Staff reported the resident's skin to nursing the to the resident's provider.
A facility incident report regarding the resident's skin was completed.
Facility nursing staff assessed and treated the pressure wounds.
The resident was transported to the hospital to have wounds further evaluated.
The facility completed an internal investigation of the incident.
The facility updated skin check procedures.

The facility updated procedures concerning resident's care and service refusals.
The facility re-educated staff on skin checks and cares.
The resident's plan of care was updated to reflect skin checks and weekly wound care.

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
	37362	A. BUILDING: _____ B. WING _____	C 05/14/2026

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 On May 5, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL373627444C/ HL373627522M. No correction orders are issued.	0 000		