Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL37826003M
Compliance #: HL37826004C

Date Concluded: May 9, 2022

Name, Address, and County of Facility Investigated:
Berkeley Heights Home
6917 Edgewood Avenue North
Brooklyn Park, MN 55428
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, facility responsibility
Inconclusive

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.

Allegation(s): The Alleged Perpetrator (AP), emotionally abused a resident when the AP called the resident a name, taunted the resident for making complaints, and attempted to bribe the resident to stop making complaints. It is also alleged that the facility frequently had moldy food, left medications out, and neglected to supervise residents.

Investigative Findings and Conclusion:

Neglect is substantiated. The facility was responsible for the maltreatment. The resident's admission documentation indicated the resident required mental health management services. The facility failed to include mental health interventions in the resident's individual abuse prevention plan (IAPP) or service plan and neglected to supervise the resident in the community. The resident was left alone at a store, had a confrontation with an employee who called police, and the store banned the resident from the store for a year.

It was inconclusive whether emotional abuse occurred. The AP sent the resident a text message stating the resident was meddling in another resident's privacy rights, inciting the other residents, and expressing herself in a condescending manner. Although the resident found this offensive and disturbing, it did not meet the definition of emotional abuse.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted law enforcement. The investigator toured the facility and observed staff/ resident interactions. The investigator reviewed resident records, personnel files, facility documents, police reports, policies and procedures related to background studies, documentation, food service, grievances, incident reports, service plans, abuse prevention plans, medication documentation, on-call nursing coverage, orientation/training, staffing, and maltreatment of vulnerable adults.

The investigation findings indicated an incident of attempted bribery came from a peer.

Regarding the moldy food allegation, a photo provided to the investigator showed moldy food in a pot. The investigator did not observe moldy food at the facility at the time of the investigation and a Food and Beverage Establishment inspection was conducted to determine the facility's compliance with the Minnesota Food Code.

The investigator observed medication locked in a cupboard and handed to residents per the medication policy.

The resident lived at the assisted living facility for less than one year, due to diagnoses including autism, hearing loss, post-traumatic stress disorder, anxiety, depression, and fibromyalgia. The resident received services from the facility including meals, set-up for grooming, medication administration, laundry, housekeeping, and safety checks. The resident's customized living services agreement indicated the resident required 15 hours of mental health management per day which included management of wandering, orientation issues, anxiety, agitation, verbal aggression, and physical aggression.

A staff member dropped off the resident at a store in the community and left the resident at the store alone. The resident interacted with a store employee about a mistaken charge she received. The store employee did not understand what the resident needed and raised her voice. The resident took out her phone and began to record the incident. The store employee called the police, who gave the resident a trespass ticket which banned the resident from the store for one year. The resident called the staff member who dropped her off.

Text messages on the resident's phone indicated the staff member arrived at the store to pick up the resident one hour after the incident.

During an interview, the resident's CADI (community options for disability inclusion) worker (a community worker whose role is to set up services for the resident) said the facility knew at the time of admission the resident required staff supervision while in the community. The CADI worker felt the facility did not provide staff with adequate training regarding the resident's diagnoses and managing their own emotions regarding the resident's mental health.

During an interview the resident's community mental health worker stated the resident had good interpersonal skills but had difficulty when under stress.

During an interview, another of the resident's community mental health workers stated the resident's service plan should require staff to remain with the resident in the community. The mental health worker stated the resident was stressed and upset for days after the incident at the store.

During an interview, the staff member who left the resident at the store stated sometimes the staff stayed with the resident and other times they left the resident. The staff member stated she would often wait in the car for the resident to call when done. The staff member stated on the day of the incident the resident called for pick up because the store called the police. The staff member stated the facility fired her after the incident, but felt it was not fair, because other staff dropped the resident off sometimes and didn't stay with her.

During an interview, the AP stated he never called the resident a liar but should not have said the resident was a meddler. The AP stated he gladly texted with the resident about her concerns and offered to meet face to face. The AP stated the resident wanted to go to the store alone sometimes and other times wanted a staff member with her. The AP stated he did not know about the store incident until the resident's care conference about a month later.

During an interview, the resident stated she needed to go to the store on the day of the incident to correct an $80.00 mistake the store made. The resident stated she asked multiple times to have a facility staff come inside the store with her because her hearing impairment and diagnosis of autism made it difficult for her to deal with situations. The resident stated the staff member dropped her off and the resident tried to conduct her business on her own. The resident stated the employees at the store did not understand her and called the police on her. The resident stated she felt embarrassed and the incident retriggered trauma.

The resident stated her preferred method of communication was through texts but felt the facility did not take her grievances seriously, including concerns about feeling threatened by a peer.

In conclusion, abuse was inconclusive, and neglect was substantiated.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: None listed
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The staff member involved in the incident is no longer employed by the facility. The AP works at a different house owned by the facility.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Mental Health and Developmental Disabilities

The Office of Ombudsman for Long-Term Care
Hennepin County Attorney
Brooklyn Park Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are 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: #HL37826004C/#HL37826003M On March 3, 2022, the Minnesota Department of Health conducted an onsite complaint investigation at the above provider, and the following immediate correction orders are issued. At the time of the complaint investigation, there were four residents receiving services under the provider's Assisted Living license. Correction orders with a period to correct that are not immediate may be issued at a later date during the investigation. The following immediate correction orders are issued for #HL37826004C/#HL37826003M, tag identification 0510 and 1290. The investigator communicated the immediate orders with the Assisted Living Director on March 3, 2022.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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	Continued From page 1 On March 10, 2022, the investigator conducted a licensing order follow-up on the immediate correction orders issued to the provider on March 8, 2022, tag identification 0510 and 1290. The immediacy was removed for tag identification 1290, and scope and severity was reduced to an E level. The immediacy for tag identification 0510 could not be removed and remains an immediate order. The following correction orders that were not immediate are issued for #HL37826003M/#HL37826004C, tag identification 0480, 0500, 0620, 0630, 0730, 1910, 2360, 2480, and 3000.	0 000		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 480	Continued From page 2 Based on observation, interview, and record review, the licensee failed to comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all four residents living at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to documentation included in the Food and Beverage Establishment Inspection Reports dated March 10, 2022. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 480		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents'	0 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 500	Continued From page 3 needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to show they had met the requirements of licensure by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required with records reviewed.	0 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 500	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: The licensee had a conditional provisional assisted living license issued on August 1, 2021. The licensee failed to ensure the following policies and procedures were in place and implemented: o Requirements in section 626.557, reporting of maltreatment of vulnerable adults o Conducting and handling background studies on employees o Handling complaints regarding staff or services provided by staff o Conducting initial and ongoing resident evaluations and assessments of resident's needs and how changes in a resident's condition are identified, managed, and communicated with staff o Infection control practices Refer to licensing order at Minnesota (MN) Statute 144G.41 Subdivision (Subd.) 1. The licensee failed to comply with Minnesota Food Code, Chapter 4626. Refer to licensing order at Minnesota (MN) Statute 626.557, Subd. 3. The licensee failed to immediately report to Minnesota Adult Abuse Reporting Center (MAARC) an allegation of suspected neglect for one of one resident (R1)	0 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 500	Continued From page 5 reviewed for maltreatment. Refer to licensing order at MN Statute 144G.60, Subd. 1. The licensee failed to ensure a background study was submitted and received for four of four employees (unlicensed personnel (ULP)-A, registered nurse (RN)-G, ULP-H, ULP-I) reviewed for background studies prior to providing direct contact services or access to residents. Refer to licensing order at MN Statute 144G.43, Subd. 3. The licensee failed to ensure accurate documentation and pertinent communications concerning care conferences, incidents, and grievances were part of the resident record for one of one resident (R1) record reviewed. Refer to licensing order at MN Statute 144G.42 Subd. 6. The licensee failed to accurately document and update the individual abuse prevention plan (IAPP) for one of one resident (R1) reviewed when R1 had an incident in the community. Refer to licensing order at MN Statute 144G.41 Subd 3. The licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. Refer to licensing order at MN Statute 144G.71 Subd. 22. The licensee failed to document the disposition of medications for one of one resident (R1) reviewed for discharge. Refer to licensing order at MN Statute 144G.91 Subd. 20. the licensee failed to document and respond to grievances of one of one resident (R1)	0 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 500	Continued From page 6 reviewed for grievances. During an interview on March 3, 2022, at 10:45 a.m., licensed assisted living director (LALD)-C stated that she was the program director for the facility, held the LALD license, and was responsible for the day-to-day operations of the assisted living facility. LALD-C stated she held the LALD license for four houses and reviewed the current assisted living regulations. Eight correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes was limited for compliance with Minnesota statutes section 144G.01 to 144G.95. TIME PERIOD OF CORRECTION: Twenty-one (21) days	0 500		
0 510 SS=I	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 510	Continued From page 7 review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control related to COVID-19 established by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The licensee failed to ensure staff wore appropriate eye protection, to screen all staff for COVID-19 symptoms, and posted signs indicating visitors were not allowed. 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). On March 3, 2022, an immediate order was issued. On March 10, 2022, additional interview and document reviews were conducted and the immediacy continued as evidence indicated staff had not been screened for COVID-19. Regarding eye protection, on March 10, 2022 staff were observed wearing appropriate eye protection. Regarding signage/visitors, on March 10, 2022, all signage prohibiting visitors had been removed. Findings include: Eye protection The Minnesota Department of Health Implementing Universal Use of Eye Protection When Community Transmission of COVID-19 is	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 510	Continued From page 8 High or Substantial guidance document dated February 16, 2022, indicated health care facilities should have policies and procedures regarding universal use of eye protection. The facility should define resident encounters internally and educate staff on use of universal eye protection. The Centers for Disease Control and Prevention (CDC) COVID-19 County Check website retrieved March 4, 2022, at 1:27 p.m. indicated Hennepin County COVID-19 community transmission was substantial. On March 3, 2022, at 10:00 a.m., the investigator entered the facility and observed unlicensed personnel (ULP)-A and ULP-B were wearing no eye protection. ULP-A quickly donned a face shield when the investigator identified herself. On March 3, 2022, at 10: 45 a.m., licensed assisted living director (LALD)-C entered the building with a mask and no eye protection. During an interview on March 3, 2022, at 3:00 p.m., LALD-C, who still did not have on eye protection, stated she did not know requirement for eye protection. Signage/visitors The Minnesota Department of Health COVID-19 Guidance: Long-term care Indoor visitation for Nursing Facilities and Assisted Living Settings guidance document dated December 29, 2021, indicated facilities must allow indoor visitation at all times and for all residents. On March 3, 2022, at 10:00 a.m., the investigator entered the facility and observed a sign on the front door reading, "For the safety of out clients and staff, no visitors, including family members,	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 510	Continued From page 9 are allowed at this time. Essential workers are expected to meet with clients outside of the facility I designated areas, such as the garage or patio." During an interview on March 3, 2022, at 3:00 p.m., LALD-C stated she was not aware of the sign indicating no visitors allowed and stated it should be removed. Screening The Centers for Disease Control and Prevention Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic guidance updated February 2, 2022, indicated facilities should establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following three criteria so that they can be properly managed: positive viral test for SARS-CoV-2, symptoms of COVID-19, or close contact with someone with SARS-CoV-2 infection. On March 3, 2022, at 10:00 a.m., the investigator entered the facility, and ULP-A asked the investigator screening questions and took the investigator's temperature, but did not document any findings on the facility COVID-19 screening log. During an interview on March 3, 2022, at 2:45 p.m., ULP-A verified he screened the investigator but did not document on the screening log. ULP-A verified that all staff are to be screened at beginning of their shift. Documentation of staff schedule and COVID-19 screening indicated the following:	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 510	Continued From page 10 On February 1, 2022, the facility had three staff scheduled, zero staff screened. On February 2, 2022, the facility had two staff scheduled, zero staff screened. On February 3, 2022, the facility had three staff scheduled, zero staff screened. On February 5, 2022, the facility had three staff scheduled, one staff screened. On February 6, 2022, the facility had four staff scheduled, one staff screened. On February 7, 2022, the facility had three staff scheduled, two staff screened. On February 8, 2022, the facility had three staff scheduled, one staff screened. On February 11, 2022, the facility had two staff scheduled, zero staff screened. On February 12, 2022, the facility had three staff scheduled, zero staff screened. On February 13, 2022, the facility had four staff scheduled, one staff screened. On February 15, 2022, the facility had four staff scheduled, one staff screened. On February 16, 2022, the facility had four staff scheduled, three staff screened. On February 19, 2022, the facility had two staff scheduled, zero staff screened. On February 20, 2022, the facility had three staff scheduled, zero staff screened. On February 28, 2022, the facility had three staff scheduled, two staff screened. On March 1, 2022, the facility had three staff scheduled, zero staff screened. On March 2, 2022, the facility had three staff scheduled, zero staff screened. Documentation of staff schedule and COVID-19 screening obtained on March 10, 2022, indicated the following: On March 5, 2022, the facility had three staff scheduled, zero staff screened.	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 510	Continued From page 11 On March 6, 2022, the facility had four staff scheduled, zero staff screened. On March 7, 2022, the facility had four staff scheduled, one staff screened On March 8, 2022, the facility had three staff scheduled, zero staff screened, On March 10, 2022, at 10 a.m., the facility had three staff scheduled, zero staff screened. During an interview on March 10, 2022, at 10:30 a.m. LALD-C stated that she provided COVID-19 policy re-training to staff on March 8, 202,2 and was surprised that all staff were not screened. Licensee's Coronavirus (COVID-19) policy dated August 1, 2021, indicated appropriate personal protective equipment (PPE) included eye protection and that the facility would screen healthcare workers at the beginning of their shift for fever and/or respiratory symptoms. TIME PERIOD FOR CORRECTION: IMMEDIATE Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control related to COVID-19 established by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The licensee failed to to screen all staff for COVID-19 symptoms. 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	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 510	Continued From page 12 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). On March 10, 2022, the MDH investigator conducted an additional interview and document review. The immediacy was continued as the findings indicated staff were not screened for COVID-19. The findings include: On March 10, 2022, the MDH investigator conducted a licensing order follow-up on the immediate correction orders issued to the provider on March 8, 2022, related to infection control. On March 10, 2022, the MDH investigator observed staff wearing appropriate eye protection and all signage prohibiting visitors removed. Documentation of staff schedule and COVID-19 screening obtained on March 10, 2022, indicated the following: On March 5, 2022, the facility had three staff scheduled, zero staff screened. On March 6, 2022, the facility had four staff scheduled, zero staff screened. On March 7, 2022, the facility had four staff scheduled, one staff screened On March 8, 2022, the facility had three staff scheduled, zero staff screened, On March 10, 2022, at 10 a.m., the facility had three staff scheduled, zero staff screened. During an interview on March 10, 2022, at 10:30 a.m., LALD-C stated that she provided COVID-19 policy re-training to staff on March 8, 2022, and	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 510	Continued From page 13 was surprised that all staff were not screened. Licensee's Coronavirus (COVID-19) policy dated August 1, 2021, indicated appropriate personal protective equipment (PPE) included eye protection and that the facility would screen healthcare workers at the beginning of their shift for fever and/or respiratory symptoms. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 510		
0 620 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment of one of one resident (R1) reviewed when the licensed assisted living director (LALD)-C became aware a staff member had left R1 alone at a local store. R1 became agitated, acted out, and the store banned R1 from entering the store in the future. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 620	Continued From page 14 resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: R1's record was reviewed. R1 moved into the assisted living facility August 9, 2021, due to diagnoses that included autism, post-traumatic stress disorder, anxiety, depression, and fibromyalgia. R1 received services that included meals, set-up for grooming, medication administration, laundry, housekeeping, and safety checks. R1's 24-hour Customized Living Services- Daily CADI (community access for disability inclusion) Agreement dated July 30, 2021 through June 30, 2022, indicated R1 required mental health management as follows: one hour per day to manage wandering, two hours per day to manage orientation issues, two hours per day to manage anxiety, one hour per day to manage repetitive behavior, two hours per day to manage verbal aggression, and three hours per day to manage other cognitive/mental health needs (symptoms of depression, symptoms of post-traumatic stress disorder, and managing autistic symptoms). R1's progress notes revealed no documentation of the incident. Unlicensed personnel (ULP)-F's employee record contained an employee termination report dated January 5, 2022, at 8:00 a.m. that indicated ULP-F left R1 at Walmart (on an unknown date), despite receiving training R1 required staff with her at all times in the community. The report	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 620	Continued From page 15 indicated the licensee terminated ULP-F's employment due to "abandoning" R1 in the community. During an interview on March 4, 2022, at 3:00 p.m. R1's community mental health worker (MHW)-D stated during a care conference on December 29, 2021, R1 informed him ULP-F had left R1 at Walmart (on an unknown date). MHW-D stated staff were to stay with R1 while out in the community. MHW-D stated while R1 tried to correct an incorrect charge with customer service at the store, things escalated as they did not understand what R1 needed, so the store called police. MHW-D stated R1 was now banned from that Walmart. MHW-D stated the incident caused significant stress for R1 and it took weeks to work through it. During an interview on March 3, 2021, at 2:56 p.m., LALD-C stated the licensee terminated ULP-F when they heard ULP-F took R1 to Walmart and "abandoned" R1 at the store. LALD-C stated ULP-F "neglected" R1 when she left her at the store alone. LALD-C stated R1 had some sort of behavioral incident with an employee and Walmart banned R1 from entering the store again. LALD-C stated she did not think of filing a report with MAARC. During an interview on March 7, 2022, at 11:37 a.m. R1 stated she asked ULP-F to accompany her into the Walmart to help her correct a mischarge of $80.00. R1 stated ULP-F just left her at the store. R1 stated she tried to conduct her transaction with customer service, but they did not understand her and called the police. R1 stated Walmart filed a no trespassing order and R1 cannot go to the store for one year.	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 620	Continued From page 16 During an interview on March 8, 2022, at 9:35 a.m. ULP-F stated she and other staff always dropped R1 off at the store and picked her up later, because it took R1 three hours to do her shopping. The investigator requested a copy of the incident report regarding the incident with R1 and but did not receive any incident reports. The Vulnerable Adult policy dated August 1, 2021, indicated all employees were mandated to report suspected abuse or neglect of a vulnerable adult to MAARC. The policy defined neglect to include the failure to provide necessary supervision of a vulnerable adult. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 620		
0 630 SS=G	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by:	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 630	Continued From page 17 Based on interview and record review the licensee failed to address R1's vulnerabilities upon admission and failed to update the individual abuse prevention plan (IAPP) for one of one resident (R1) reviewed. R1's 24-hour Customized Living Services-Daily CADI (community access for disability inclusion) Agreement indicated R1 required mental health management, but R1's IAPP did not address this as vulnerabilities. R1 also had an incident in the community when left alone in a store. The licensee failed to update R1's IAPP to reflect the incident, R1's vulnerability in the community, and specific measures to be taken to minimize the risk to R1. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1's record was reviewed. R1 moved into the assisted living facility August 9, 2021, due to diagnoses that included autism, post-traumatic stress disorder, anxiety, depression, and fibromyalgia. R1's 24-hour Customized Living Services-Daily CADI Agreement dated July 30, 2021, through June 30, 2022, indicated R1 required mental health management as follows: one hour per day to manage wandering, two hours per day to manage orientation issues, two hours per day to	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 630	Continued From page 18 manage anxiety, one hour per day to manage repetitive behavior, two hours per day to manage verbal aggression, and three hours per day to manage other cognitive/mental health need (symptoms of depression, symptoms of post-traumatic stress disorder, and managing autistic symptoms). R1's IAPP dated August 9, 2021, indicated the following areas of vulnerability and interventions: hearing difficulties (staff were instructed to speak slowly), and chronic pain (staff were supposed to notify a nurse promptly for a change in condition). R1's IAPP indicated R1 "does not have any areas of vulnerability requiring interventions at this time". R1's Nurse Reassessment Visit dated December 9, 2021, noted no concerns, "alert and oriented X3, consumed 80% of meal. Vitals stable per baseline, denied any GI issues and RR issues, able to communicate without concerns." Unlicensed personnel (ULP)-F's employee termination report dated January 5, 2022, at 8:00 a.m. indicated ULP-F left R1 at Walmart (on an unknown date), despite training that R1 required staff with her at all times in the community. The report indicated the licensee terminated ULP-F's employment due to "abandoning" R1 in the community. During an interview on March 7, 2022, at 10:35 a.m. registered nurse (RN)-G stated she provided on-call nursing coverage for the licensee beginning February 2022. RN-G stated she never met R1, never completed an assessment of R1, or updated R1's IAPP. During an interview on March 8, 2022, at 2:32	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 630	Continued From page 19 p.m. RN-L stated she was out of the country all of December 2021 and did not hear about an incident with R1 in the community until she returned on January 6, 2022. RN-L stated she did not assess R1's vulnerability in the community as she assumed the RN covering in her absence completed an assessment. The investigator attempted to interview RN-M, who identified as the nurse who covered in RN-L's absence. RN-M declined an interview. Licensee's Assessment and Reassessment policy dated August 1, 2021, indicated the RN would conduct a comprehensive assessment and ongoing resident monitoring based on changes in the needs of the resident. The investigator requested an IAPP policy, but no policy was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 630		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 730	Continued From page 20 medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure accurate documentation and pertinent communications concerning care conferences, incidents, and grievances were part	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 730	Continued From page 21 of the resident record for one of one resident (R1) record reviewed. This had the potential to affect all four of the licensee's current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: R1's record was reviewed. R1 moved into the facility on August 9, 2021, due to diagnoses that included autism, post-traumatic stress disorder, anxiety, depression, and fibromyalgia. Unlicensed personnel (ULP)-F's employee record contained an employee termination report dated January 5, 2022, at 8:00 a.m. indicated ULP-F left R1 at Walmart (on an unknown date), despite training R1 required staff with her at all times in the community. The report indicated the licensee terminated ULP-F's employment dur to "abandoning" R1 in the community. R1's record lacked documentation of the Walmart incident, investigation of the Walmart incident, a care conference, during which the incident was discussed, or documentation of R1 complaints. During an interview on March 3, 2022, at 2:56 p.m. licensed assisted living director (LALD)-C verified there were no care conference, incidents, or grievances in R1's record. Licensee's Resident Record- Documentation	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
0 730	Continued From page 22 policy dated August 1, 2021, indicated staff were to document in a resident's chart information about new problems, resident concerns, changes in resident condition, and incidents. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 730		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received for four of four employees (unlicensed personnel (ULP)-A, registered nurse (RN)-G, ULP-H, ULP-I) reviewed for background studies, prior to providing direct contact services, or access to residents. This had the potential to affect all four residents of the facility. This practice resulted in a level three violation (a	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
01290	Continued From page 23 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: ULP-A was hired by the licensee to provide direct care services to the licensee's residents. The schedule indicated ULP-A provided direct care services independently on January 10, 13, 14, 19, 26, and 29, 2022; February 4, 18, and 19, 2022; and March 2, 2022. The investigator observed ULP-A provide services to residents on March 3, 2022. ULP-A's employee file did not contain a background study at the time of the investigation. RN-G was hired by the licensee to provide on-call nursing services to the licensee's residents and supervise unlicensed personnel under the licensee's assisted living license. Licensee's facility documentation did not reveal dates and/or times that RN-G provided services to residents. RN-G's employment file included a background study clearance dated July 11, 2021, for a different facility owned by the licensee. ULP-H was hired by the licensee to provide direct care services to the licensee's residents. The licensee's schedule indicated ULP-H provided services independently on March 2, 2022. ULP-H's employment file included a background study clearance dated February 21, 2022, for a different facility owned by the licensee. ULP-I was hired by the licensee to provide direct	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
01290	Continued From page 24 care services to the licensee's residents. The licensee's schedule indicated ULP-I provided services on January 19 and 23, 2022; February 1, 8, and 9, 2022. ULP-I's employment file contained a background study clearance dated December 7, 2021, for a different facility owned by the licensee. During an interview on March 7, 2022, licensed assisted living director (LALD)-C confirmed that ULP-A, RN-G, ULP-H, and ULP-I provided services to residents at the facility. LALD-C stated she did not submit a background study for RN-G because the previous nurse left with short notice. LALD-C stated she submitted background studies for ULP-A and ULP-H on March 6, 2022, after the investigation began. The licensee provided no evidence of a plan for continuous, direct supervision of ULP-A, RN-G, ULP-H, or ULP-I by a qualified staff person in the absence of a background study. The Background Study policy dated June 2021 indicated the licensee conducted a background study on all employees. The policy indicated that no employee may provide direct services or have independent contact with residents until acceptable results have been received, except under the direct supervision (eyesight) of another qualified staff person. TIME PERIOD FOR CORRECTION: IMMEDIATE On March 10, 2022, the investigator conducted a licensing order follow-up on the immediate correction orders issued to the provider on March 8, 2022, tag identification 0510 and 1290. The immediacy was removed for tag identification 1290, and scope and severity was reduced to a	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
01290	Continued From page 25 level E.	01290		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document the disposition of medications for one of one resident (R1) reviewed for discharge. R1 self-discharged and staff did not document the medication name, strength, prescription number, or quantity given to R1. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
01910	Continued From page 26 resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: R1's record was reviewed. R1 moved into the facility on August 9, 2021, due to diagnoses that included autism, post-traumatic stress disorder, anxiety, depression, and fibromyalgia. R1's service plan dated August 9, 2021, indicated R1 received services from the assisted living that included medication administration. R1's medication administration record (MAR) dated February 2022, indicated R1 received the following medications: fluoxetine (an anti-depressant), chlorhexidine (a rinse to treat gingivitis), meloxicam (a non-steroidal anti-inflammatory medication for pain), prazosin (a medication for high blood pressure), and trazodone (an anti-depressant). R1's progress note dated February 26, 2022, from 7:00 a.m. to 1:00 p.m. indicated R1 told staff at 8:00 a.m. she was moving out of the facility. R1's progress note indicated at 10:04 a.m. a U-Haul came to move R1. The progress note indicated the owner came to the facility (unknown time) to ask R1 about moving, and the administrator came to the facility at 12:00 p.m. to ask R1 why she was leaving. R1's progress note indicated that R1 left the facility at 1:35 p.m. with her prescribed medication per the approval of the nurse. R1's record lacked documentation of disposition	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
01910	Continued From page 27 of R1's medications with the name, strength, prescription number, or quantity of medications sent with R1. ULP-E's cell phone video dated Saturday February 26, 2022, at 1:59 p.m. was reviewed by the investigator on March 3, 2022, at 4:42 p.m. ULP-E can be heard stating the medications belong to R1 as she is "self-discharging". ULP-E further stated "The nurse has been called. Packing up her real medications and her back-up medications and everything is about to be released to her. I did this video as evidence that everything has been given to her." The video showed several bubble packs of medications and bottles (unknown if empty or with medication in them). During an interview on March 3,2022, at 4:45 p.m. ULP-E stated she did not know what to do with the medications, so she made a video on her cell phone. ULP-E stated she had called the registered nurse (RN-G) multiple times, but the calls went to voicemail. ULP-E stated the nurse responded to a text message and spoke with R1 but gave ULP-E no direction except to give R1 her medications. ULP-E stated she did not fill out anything but wrote in a progress note she sent all R1's medications with her. During an interview on March 7, 2022, at 10:35 a.m. RN-G stated she did not recall missing any calls from ULP-E on Saturday February 26, 2022. RN-G stated she received a text message from ULP-E saying R1 was leaving and wanted her medications. RN-G stated she spoke on the phone with R1 around 1:30 p.m. and asked R1 to wait for RN-G to come to the facility, but R1 was packed up and wanted to go. RN-G stated she gave the approval to ULP-E to give R1 all her	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
01910	Continued From page 28 medications. RN-G stated she thought she (RN-G) documented a discharge note for R1 but must have forgotten. The Licensee's Disposition and Disposal of Medications policy dated August 1, 2021, indicated that unused portions of medications being managed by the facility will be given to the resident. The policy indicated upon disposition, the following information will be documented in the resident's record: name, strength, and prescription number of the medication, quantity, whom the medications were given, date of disposition, and name/signature of staff involved in disposition. TIME PERIOD FOR CORRECTION: Seven (7) Days	01910		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On March 3, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
02360	Continued From page 29 which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		
02480 SS=F	144G.91 Subd. 20 Grievances and inquiries Residents have the right to make and receive a timely response to a complaint or inquiry, without limitation. Residents have the right to know and every facility must provide the name and contact information of the person representing the facility who is designated to handle and resolve complaints and inquiries. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to respond to grievances of one of one resident (R1) reviewed for grievances. R1 communicated several concerns to the licensee, without resolution. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: R1 moved into the facility on August 9, 2021, due to diagnoses that included autism, post-traumatic stress disorder, anxiety, depression, and fibromyalgia. R1`s record lacked evidence of grievances,	02480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
02480	Continued From page 30 responses to grievances, or attempts to resolve grievances. During an interview on March 3, 2022, at 2:56 p.m. licensed assisted living director (LALD)-C stated R1 had multiple grievances that were not documented. LALD-C stated she may have some e-mails with grievances R1 had expressed, (but did not provide them). LALD-C stated R1's grievances contained complaints about staff lack of training, need for more space, and threats from a peer. LALD-C confirmed licensee's grievance policy had a form for residents and staff to fill out but, "We never use it. We just talk about the issues." During an interview on March 7, 2022, at 11:37 a.m., R1 stated she sent multiple grievances to LALD-C by text as it was her preferred manner of communication. R1 stated she had multiple incidents with a peer who threatened her. R1 stated she complained to administration about staff mocking a peer's psychiatric symptoms, trying to pay off R1 to stop making complaints, and an incident at Walmart where staff left her alone. R1 stated she did not feel the licensee took her complaints seriously because they never did anything about them. Licensee's Grievance policy dated August 1, 2021, indicated the process for investigating a quality concern included the following steps: The employee receiving the information documented the information. The employee attempted to resolve the problem immediately, and if unresolved, the employee turned over the documentation to their supervisor. The supervisor notified the complainant of receipt of the document, a resolution plan was developed, and the supervisor notified the complainant in writing	02480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
02480	Continued From page 31 within 14 days. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	02480		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
03000	Continued From page 32 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment of one of one resident (R1) reviewed when the licensed assisted living director (LALD)-C became aware a staff member had left R1 alone at a local store. R1 became agitated, acted out, and the store banned R1 from entering the store in the future. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include:	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
03000	Continued From page 33 R1's record was reviewed. R1 moved into the assisted living facility August 9, 2021, due to diagnoses that included autism, post-traumatic stress disorder, anxiety, depression, and fibromyalgia. R1 received services that included meals, set-up for grooming, medication administration, laundry, housekeeping, and safety checks. R1's 24-hour Customized Living Services- Daily CADI (community access for disability inclusion) Agreement dated July 30, 2021 through June 30, 2022, indicated R1 required mental health management as follows: one hour per day to manage wandering, two hours per day to manage orientation issues, two hours per day to manage anxiety, one hour per day to manage repetitive behavior, two hours per day to manage verbal aggression, and three hours per day to manage other cognitive/mental health needs (symptoms of depression, symptoms of post-traumatic stress disorder, and managing autistic symptoms). R1's progress notes revealed no documentation of the incident. Unlicensed personnel (ULP)-F's employee record contained an employee termination report dated January 5, 2022, at 8:00 a.m. that indicated ULP-F left R1 at Walmart (on an unknown date), despite receiving training R1 required staff with her at all times in the community. The report indicated the licensee terminated ULP-F's employment due to "abandoning" R1 in the community. During an interview on March 4, 2022, at 3:00 p.m. R1's community mental health worker (MHW)-D stated during a care conference on December 29, 2021, R1 informed him ULP-F had	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
03000	Continued From page 34 left R1 at Walmart (on an unknown date). MHW-D stated staff were to stay with R1 while out in the community. MHW-D stated while R1 tried to correct an incorrect charge with customer service at the store, things escalated as they did not understand what R1 needed, so the store called police. MHW-D stated R1 was now banned from that Walmart. MHW-D stated the incident caused significant stress for R1 and it took weeks to work through it. During an interview on March 3, 2021, at 2:56 p.m., LALD-C stated the licensee terminated ULP-F when they heard ULP-F took R1 to Walmart and "abandoned" R1 at the store. LALD-C stated ULP-F "neglected" R1 when she left her at the store alone. LALD-C stated R1 had some sort of behavioral incident with an employee and Walmart banned R1 from entering the store again. LALD-C stated she did not think of filing a report with MAARC. During an interview on March 7, 2022, at 11:37 a.m. R1 stated she asked ULP-F to accompany her into the Walmart to help her correct a mischarge of $80.00. R1 stated ULP-F just left her at the store. R1 stated she tried to conduct her transaction with customer service, but they did not understand her and called the police. R1 stated Walmart filed a no trespassing order and R1 cannot go to the store for one year. During an interview on March 8, 2022, at 9:35 a.m. ULP-F stated she and other staff always dropped R1 off at the store and picked her up later, because it took R1 three hours to do her shopping. The investigator requested a copy of the incident report regarding the incident with R1 and but did	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME LLC	6917 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
03000	Continued From page 35 not receive any incident reports. The Licnsee's Vulnerable Adult policy dated August 1, 2021, indicated all employees were mandated to report suspected abuse or neglect of a vulnerable adult to MAARC. The policy defined neglect to include the failure to provide necessary supervision of a vulnerable adult. TIME PERIOD FOR CORRECTION: Seven (7) Days	03000		