Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306924503M
Compliance #: HL306927716C

Date Concluded: August 29, 2023

Name, Address, and County of Facility Investigated:
Brookdale North Oaks
300 Village Center Drive
North Oaks, MN 55127
Ramsey County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: James Larson, RN
Special Investigator

Finding: Not Substantiated

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):
The facility neglected the resident when staff failed to assess and monitor the resident with a change in condition after the resident fell. The resident was later sent to the hospital, but only after being seen by family members who reported a change in condition.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although facility staff initially assessed and treated the resident after an unwitnessed fall, she later developed symptoms that required hospitalization. It is unable to be determined if the action or inaction of facility staff was the direct cause of the resident's condition or progression of her injury.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also interviewed the resident's family. The investigation included review of the resident's medical record, nursing assessments, service

plans, care plans, and progress notes. The investigator also conducted an onsite visit and observed staff's interactions with residents.

The resident resided in an assisted living facility memory care unit. The resident's diagnoses included Parkinson's disease, dementia, and Balint's syndrome (a rare neurologic disease that affects visual perception). The resident's service plan directed staff to assist with medication administration, activities of daily living, laundry, housekeeping services, and meals.

Complaint documents indicated the resident fell one month prior and sustained injuries of a bilateral odontoid fracture of C1, (a bone in the neck) as well as T12 (a bone in the low back) compression fracture, and frontal scalp lacerations which required stiches. The resident was admitted to the hospital for further treatment and later returned to the facility.

Two weeks after returning to the facility, the resident fell in her room. Facility staff assessed the resident for injuries, documented there was no apparent harm to the resident, and assisted her back to bed. Hours later, a family member and an outside agency therapist came to visit the resident and alerted staff of a change in the resident's condition. New symptoms were observed including the resident not holding her head in a midline position. The nurse contacted emergency medical services (EMS) and the resident was sent to the emergency room for an evaluation. The resident was again admitted to the hospital for observation.

Following the hospital stay, the resident admitted to a skilled nursing facility and did not return to the facility.

During an interview with an unlicensed staff member at the facility, they recalled the unwitnessed fall where the resident sustained the laceration but could not recall any details of the subsequent fall.

Current administrative members were not employed at the time the alleged incident occurred and had no knowledge of the incident.

The resident's family was interviewed and expressed concerns with care provided at the facility and the delay in staff's response to the resident's fall.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: N/A

Action taken by facility: None

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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

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
	30692	A. BUILDING: _____ B. WING _____	C 08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE NORTH OAKS	300 VILLAGE CENTER DRIVE NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, 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: #HL306927716C/#HL306924503M On August 14, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 34 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL306927716C/#HL306924503M, tag identification 0650 and 2240.	0 000	STATE HOME CARE PROVIDER/ASSISTED LIVING PROVIDER POC TEXT Assisted Living Provider 144G. Minnesota Department of Health is documenting the State 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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 650 SS=G	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one unlicensed personnel (ULP)-D with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 650		

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0 650	Continued From page 2 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). The findings include: ULP-D was hired and began providing care on November 22, 2022. ULP-D's record lacked a Department of Human Services (DHS) background study (BGS) relating to this facility. Review of DHS NetStudy records indicated a completed BGS was requested and cleared for enployment on August 18, 2021, for another licensed facility. ULP-D's record contained a "mycertiphi.com" form dated November 18, 2022, which indicated no criminal history of state and other offence findings, although this study was not completed by DHS as required. On August 14, 2023, at approximately 11:00 a.m., licensed assisted living director (LALD) -A indicated all employees are required to have a background study in their record. A copy of a DHS background study for ULP-D was requested, however, none was provided. The licensee did not provide a policy or procedure related to background checks when requested. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 650		

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02240	Continued From page 3	02240		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not	02240		

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02240	Continued From page 4 retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided and a written acknowledgement was received for one of one resident (R1) residing at the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) 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). The findings include: R1 began receiving services under the assisted living licensure on April 19, 2022. R1's diagnoses included Parkinson's Disease, dementia and Balint's syndrome. R1's service plan dated June 1, 2022, indicated R2 received services which included medication management, meals, assistance with grooming, laundry, and housekeeping. R1's records included an authenticated	02240		

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02240	Continued From page 5 acknowledgement form signed and dated November 18, 2022, which indicated R1's legally responsible party, received a copy of the Minnesota Home Care Bill of Rights. During an interview on August 14, 2023, at 12:00 p.m., the licensed assisted living administrator (LALD)-A verified the Home Care Bill of Rights was used and the chart content would be replaced with the updated Minnesota Assisted Living Bill of Rights. The licensee did not provide a policy or procedure related to the Minnesota Assisted Living Bill of Rights when requested. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		