Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL337724444M
Compliance #: HL337727485C

Date Concluded: July 24, 2023

Name, Address, and County of Licensee Investigated:
The Sanctuary at Brooklyn Center
6121 Brooklyn Boulevard
Brooklyn Center, MN 55429

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

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Not Substantiated

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

Initial Investigation Allegation(s):
The facility neglected the resident when staff failed to supervise the resident. The resident eloped from the facility for an undetermined amount of time and was found lying outside in a snowbank. The resident developed frostbite on his hands.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident was independent with most activities, frequently left the facility on his own, and the residents plan of care was being followed. When staff discovered the resident was missing, they searched for the resident and contacted law enforcement. The resident was found outside the facility in a snowbank. The resident was transferred to the hospital with frostbite on his hands/ fingers.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and a family member. The investigation included review of the resident's medical records, facility policies and procedures, and personnel files. Also, the investigator observed cares and staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included chronic kidney disease. The resident's service plan included assistance with medication management, housekeeping, and laundry. The resident's assessment indicated the resident was independent with most activities.

When interviewed, staff members stated a staff entered the resident's apartment to administer his morning medications. The resident was not in his apartment which was unusual. This staff member notified other staff the resident was not in his room and staff began to search throughout the building for the resident. The staff stated the resident would leave the building without signing out, so when the resident wasn't found in the building, staff called his family to see if he was with them. The family member stated the resident was not with them, but suggested he might have gone to the store. Staff members continued to search for the resident outside the facility but could not locate him. Staff notified facility leadership and contacted law enforcement. When staff leadership arrived at the facility, they located the resident outside lying in a snowbank. Staff assessed the resident and called 911. The resident was taken to the hospital via ambulance.

The resident's hospital record indicated the resident was diagnosed with frostbite on both his hands. The resident's right pinky finger was amputated, due to the extent of the damage to that finger.

The facility incident report indicated the resident had left his pendant and cell phone in his apartment, so he had been unable to call staff for help. There was no video available.

The resident's medical record indicated staff last saw the resident at his scheduled medication administration time the night before, approximately 12 hours prior to discovering the resident was missing. The residents plan of care was being implemented when the resident went missing, and the resident had no history of elopement.

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, unable due to cognitive status.
Family/Responsible Party interviewed: No, attempted to contact.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility completed an internal investigation. After the resident returned from the hospital, he was transferred to the facility's locked memory care unit.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33772	A. BUILDING: _____ B. WING _____	C 07/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT BROOKLYN CENTER	6121 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments On July 5, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL337727485C/#HL337724444M and HL337729377C/HL337725463M. No correction orders are issued.	0 000	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 ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	