DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL36107001M
**Compliance #:** HL36107002C

**Date Concluded:** January 27, 2023

**Name, Address, and County of Licensee Investigated:**
Bella Vie Living LLC
7001 Emerson Avenue North
Brooklyn Center, Minnesota
Hennepin County

**Facility Type: Assisted Living Facility (ALF)**

**Evaluator's Name:** Nicole Myslicki, RN
Special Investigator

**Finding: 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.

**Initial Investigation Allegation(s):**
The alleged perpetrator (AP) abused resident #1 and resident #2 when the AP restricted their rights to leave the facility, and gaslighted and manipulated them after finding out the residents wanted to move. Additionally, the facility neglected resident #1 and resident #2 when staff failed to provide services according to their care plans.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined abuse and neglect were inconclusive. There was a lack of evidence in this investigation, due in part to the change of ownership which took place shortly after this incident occurred. Additionally, there was conflicting information between interviews and facility records.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted law enforcement. The investigation included

review of the residents' medical records, the AP's personnel record, facility incident reports, and complaints. Also, the investigator observed staff interactions with the residents.

The incident occurred before a change of ownership of the facility took place. Due to this change of ownership, some documentation was unable to be obtained for the investigation, including incident reports and grievances. Additionally, the previous owner did not retain certain documents, including a staff schedule indicating who worked during the timeframe.

The residents resided in an assisted living facility. At the time of the onsite visit, both resident's still lived at the facility.

Resident #1's diagnoses included high blood pressure and sleep apnea. Resident #1's care plan included assistance with medication administration, applying and removing his mask for sleep apnea, and homemaking. Resident #1's assessment identified resident #1 as susceptible to abuse by others in the home environment and unable to report abuse or neglect concerns.

Resident #2's diagnoses included weakness on one side of the body and traumatic brain injury. Resident #2's care plan included assistance with medication administration, homemaking, and activities of daily living as needed. Resident #2's assessment identified resident #2 as susceptible to abuse by others in the home environment and unable to report abuse or neglect concerns.

Facility meeting notes indicated the AP and licensed assisted living director #1 met with residents #1 and #2 multiple times to address their concerns. This document included the concerns, follow up, and how the concerns were rectified. The residents had concerns regarding shower assistance and liquid medication. Both residents had concerns regarding clothing and laundry, size of their refrigerator, and staff issues. The facility addressed these concerns in various ways including offering showers to resident #1 daily, increase frequency of showers for resident #2, working with the pharmacy and provider for changing over as many medications to liquid form as possible, purchasing new clothing items, shoes, coats, and blankets for both residents, buying the residents a larger refrigerator for their room, replacing hallway lights with brighter bulbs, disciplining staff, and removing staff as needed.

During an interview, the licensed assisted living director #1 stated the residents had many concerns with their care in general. The facility fired staff, changed staff schedules, and moved staff to and from different facility locations to try to please the residents. He and the AP also held multiple conferences with the residents to go over concerns, and many of them were addressed. He and the AP would also have staff check in on the residents almost daily to ask them if they had any new concerns, so they could make sure concerns were addressed. Licensed assisted living director #1 stated the facility or a staff member never restricted the residents to leave the facility or have visitors.

During an interview, the AP stated he and licensed assisted living director #1 were both licensed assisted living directors and oversaw the facility equally. Sometimes, however, the two residents would dislike one or the other more, which had been the case during the time of this incident. The two residents wanted to find another living facility. The AP tried to encourage the residents to stay and did things to make them as happy and as comfortable as possible, including buying a refrigerator for them and fixing whatever the residents stated needed fixing. Soon, the residents stated they felt like they were being manipulated by the AP, so the AP reduced his time at the facility. The AP asked licensed assisted living director #1 interact with the residents more during this time, so the residents would not feel like they were being manipulated by him into staying at the facility. The AP stated he did not refuse entry when someone came to assess the residents. He had not been told anyone was coming from another facility to assess the residents, so he instructed the nurse to have their manager call him first.

During an interview, resident #1 stated his and resident #2’s mental states worsened after coming to live at the facility.

During an interview, resident #2 stated the AP did not allow resident #1 to go on walks for two to three weeks. Resident #2 also stated the AP denied entry to another facility’s nurse for an assessment, but the nurse came back two or three days later to complete the assessments.

In conclusion, the Minnesota Department of Health determined abuse and neglect were inconclusive.

**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.

**Abuse: Minnesota Statutes section 626.5572, subdivision 2.**
"Abuse" means:
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

**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.

**Vulnerable Adult interviewed**: Yes.
**Family/Responsible Party interviewed**: Yes. Residents are their own responsible parties and each other's significant others.
**Alleged Perpetrator interviewed**: Yes.

**Action taken by facility:**
The facility had been holding conferences with the residents. The AP limited his time at the facility prior to the change of ownership.

**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

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36107 | A. BUILDING: ______ B. WING ______ | C 11/10/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BELLA VIE LIVING LLC** | **7001 EMERSON AVENUE NORTH BROOKLYN CENTER, MN 55430** |

| (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<br><br>On November 10, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL36107002C/#HL36107001M. No correction orders are issued. | 0 000 | The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes.<br><br>The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | |

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE