Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL364693203M
Compliance #: HL364695221C

Date Concluded: July 25, 2023

Name, Address, and County of Licensee Investigated:
Berkeley Heights Homes
1808 Meadowwood Court
Brooklyn Park MN, 55444
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 facility neglected two residents (resident #1 and resident #2) when they failed to provide supervision. This resulted in resident #2 threatening resident #1 of physical harm and breaking resident #1's door. Resident #1 escaped through a window and was fearful to return.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to implement measures to protect resident # 1 from resident # 2's violent outbursts. Resident # 2 had a history of repeated physical and verbal aggression toward resident # 1 and facility staff.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted case workers, behavior health workers, and law enforcement. The investigation included review of the resident's records,

hospital documentation, police reports, and employee files. Also, the investigator toured the facility and observed staff and resident interactions.

The residents resided in an assisted living facility. Resident #1's diagnoses included psychosis, personality disorder, and anxiety. The resident's service plan included assistance with medication administration, meal preparation, laundry, and housekeeping. The resident's nursing assessment indicated the resident was alert but had mild memory impairment. The resident walked independently.

Resident #2's diagnoses included bipolar disorder, post-traumatic stress disorder (PTSD), fetal alcohol syndrome, and borderline mental retardation. The resident's service plan included assistance with medication administration, meal preparation, laundry, and housekeeping. The resident's nursing assessment indicated the resident was alert. The resident was verbally and physically aggressive. The resident walked independently.

Facility incident reports indicated there were multiple episodes of resident # 2's physical aggression toward resident # 1. During a one-month period, an incident report indicated resident # 2 broke resident # 1's door and threatened to beat her, which caused resident # 1 to climb through a window to escape. Three weeks prior to the incident resident # 2 challenged resident # 1 to come out of her room so she could beat her. One incident resulted in resident # 1 receiving medical care. Facility incidents reports indicated altercations continued to occur and three months later, resident # 2 choked resident # 1 which resulted in law enforcement removing resident # 2 from the facility. Additionally, an incident reported indicated resident # 2 was physically aggressive toward staff members and attacked a staff member with a knife.

Resident # 1 received an injury from an altercation which staff documented the circumstances in resident # 1's progress notes. Resident # 1's progress notes indicated resident # 2 pushed resident # 1 during an argument and resident # 1 fell to the ground. Resident # 1 groaned in pain and required law enforcement intervention. Resident # 1 declined medical care at the time of the incident, however she sought medical care three days later because she continued to have pain in her side and abdomen. Medical providers evaluated the resident and diagnosed her with a rib injury. The resident returned to the assisted living facility.

Within the one-month time frame, law enforcement records indicated they arrived at the facility eight times for physical aggressions involving resident # 2. Law enforcement removed resident # 2 from the facility due to her violent behavior twice, within the same time frame.

Resident # 1's nursing assessments failed to identify she was susceptible to abuse. The assessment lacked interventions to reduce her risk of abuse. The plan of care which directs staff on how to care for the resident, failed to identify resident #1's behavior, susceptibility to abuse, and actions caregivers should provide to protect her.

Resident # 2's nursing assessment failed to identify resident # 2 was physically aggressive, however an assessment did indicate she was at risk to abuse other residents. Her assessments lacked interventions to prevent or reduce the risk of her abusing others. The plan of care which directs staff how to care for the resident, failed to identify resident # 2 had physically abusive behavior and indicated she was "cooperative". The plan of care failed to identify what actions caregivers should provide to protect her.

During an interview, an unlicensed personnel (ULP) said most of the time resident # 2 targeted resident # 1. The ULP said resident # 2 received hospitalization for her aggressive behavior, but returned to the facility after the hospital stays. The ULP said physicians started medication for resident # 2, however she smoked "weed" and her aggressive behaviors escalated and became uncontrollable. The ULP said the staff were in transition when some of the altercations occurred between the two residents which is why care plans lacked interventions for behavior management.

During an interview, a manager said resident # 1 was verbally aggressive but not physically aggressive. The manager said resident # 1 discharged from the facility of her own accord. The manager said resident # 2 was "very" physically aggressive. The manager said resident # 2 "ransacked" the office and broke things which led to her removal from the facility by law enforcement. The manager said resident #2 was at the hospital and there were no plans for her to return to the facility.

During an interview, resident # 1 said she never felt safe while at the facility.

Resident # 2 was unable to be interviewed.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

"Substantiated" means:
"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.

Vulnerable Adult interviewed: Resident #1, Yes. Resident #2, No unable.
Family/Responsible Party interviewed: No. Not Applicable.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility coordinated care with resident # 1 and resident # 2's case managers.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment. 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 Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Brooklyn Park City 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
	36469	A. BUILDING: _____ B. WING _____	R-C 09/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOMES LLC	1808 MEADOWWOOD COURT BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments On September 18, 2023, the Minnesota Department of Health conducted a licensing order follow-up related to correction orders issued for complaint #HL364695221C/#HL364693203M. Berkeley Heights Homes was found to be in compliance with state regulations.	{0 000}		