Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL364698304M
Compliance #: HL364695429C

Date Concluded: September 6, 2023

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Jennifer Segal RN, BSN
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 a resident when the facility failed to manage and administer the resident's clonazepam (anti-anxiety) according to physician orders.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility implemented safeguards for the resident's clonazepam and coordinated with the resident, prescriber, and care team.

The investigator interviewed facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included a review of the resident's medical record, medication management and administration policies, facility grievances, and staff training records. The investigator observed the facility's medication storage for scheduled and controlled medications and observed staff administering and documenting resident medications.

The resident lived in the assisted living facility. The resident's diagnoses included borderline personality disorder, anxiety, depression, and post-traumatic stress disorder. The resident's service plan included assistance with behavior and medication management. The resident's nursing assessment indicated a history of chemical/medication abuse and drug-seeking behavior with a risk of overdose.

The resident's prescriptions included clonazepam, as needed/requested by the resident (up to three times daily) for severe anxiety. In addition, staff administered the resident his regular scheduled medication at 8:00 a.m. and 8:00 p.m. daily.

A progress note indicated the resident began visiting a new friend and would be away from the facility for days. The resident's care team consulted due to identified risks and determined the resident would not be allowed access to more than three tablets of clonazepam at a time. The resident disagreed, and the nurse contacted the provider for advisement. A new prescription indicated the provider changed the directions of clonazepam from as needed to scheduled three times a day. In addition, the provider noted the resident was allowed a two-day supply of clonazepam when out of the facility.

The following day, a progress note indicated the resident obtained medications for his leave and later convinced another staff that he did not receive the medication. The nurse arrived at the facility before the resident and friend left and determined the resident had more medication than allowed and requested the resident return the additional day's dose, but the resident refused. The progress note indicated the resident's friend became verbally aggressive, shouted racial slurs at the staff and slammed the door closed. Staff called 911 for assistance, but the resident and friend left before the police arrived. The progress note indicated concern with the resident's drug-seeking behavior as it "spiraled" and notified the resident's care team and facility management of concerns.

Two days later, the facility received a fax after hours from the provider directing staff to release all the resident’s medications to the resident.

When interviewed the nurse stated the resident was angry when the nurse would not release the resident all his medications that evening. The nurse stated she wanted to ensure the provider was aware of the resident’s history and concern for safety related to medication abuse. In addition, the nurse stated she was not comfortable with the responsibility of giving the resident all his medications.

The following day, progress notes indicated the nurse contacted the provider and explained the concern for the resident's safety and the potential risk of releasing all medications to the resident. The nurse noted the facility could not be responsible for tracking the controlled medications if the facility was not administering the medication. The provider responded to the nurse via fax to disregard the last order and indicated the facility should not release all

medications to the resident. Instead, the resident and care team, including the provider, would have a care conference to determine a plan.

One evening before the care conference, the resident accused the staff of forging his name and forcefully removed a medication logbook from the staff. The facility called 911 for assistance, but the resident left with the medication book before the police arrived.

Approximately two weeks later progress notes indicated, during the care conference the resident told the team he believed staff hacked his phone and attempted to obtain evidence against the resident. The resident stated he did not feel safe and feared the staff might kill him. The resident and team agreed the resident would move out of the facility with appropriate notice and assistance in locating a new facility. The resident continued to pick up medications every two days from the facility for the next two months until the resident moved to a new facility.

A discharge note indicated the facility nurse required the nurse of the new facility to pick up all the resident's medications for a count of all medications and safe handoff. Both nurses signed the discharge paperwork.

During an interview, the nurse stated her primary responsibility was managing the resident's medications in the safest way possible. The nurse stated based on the resident’s assessment and history, the resident could not manage his medications without staff assistance.

During interview, a facility manager stated similar experiences and concerns for the resident’s health and safety and explained the facility tried different interventions with the resident and supported staff, however, the situation was unsafe for all.

During interview, a case manager shared similar observations and concerns for the resident’s health and safety. The case manager stated the medication issue experienced at the facility appears to be a pattern for the resident.

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, did not respond to interview attempts.
Family/Responsible Party interviewed: Not applicable.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
The facility coordinated regularly with the resident and team, arranged for care conference, provided support and education to staff members, and the facility nurse spent additional time working closely with the resident and staff for safe medication management.

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
	36469	A. BUILDING: _____ B. WING _____	C 08/18/2023

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 August 18, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL364698304M, HL364695429C. No correction orders are issued.	0 000		