Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL370908484M
Compliance #: HL370905742C

Date Concluded: March 12, 2024

Name, Address, and County of Licensee Investigated:
Bright Path Homes
6800 Quail Avenue North
Brooklyn Center, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Katie Germann, RN, Special Investigator

Finding: Substantiated, facility responsibility

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):
1. The facility neglected a resident when the facility failed to supervise the resident when the resident ingested drugs resulting in the resident's hospitalization.

2. In addition, the facility neglected to supervise a resident when the resident had non-consensual sexual relations with another resident in the facility.

Investigative Findings and Conclusion:

1. The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility was aware of the resident's illegal drug use in the facility and failed to assess the resident to determine interventions and/ or safety monitoring to

ensure the residents safety. The resident was transferred to the hospital and tested positive for Cocaine and Oxycodone.

2. The Minnesota Department of Health determined neglect was not substantiated. Both residents denied any sexual activity occurred in the facility. There was no further information regarding sexual contact between the residents.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted the resident's case manager. The investigation included review of the resident's hospital records, medical records, facility policies and procedures, and police reports.

The resident resided in an assisted living facility with diagnoses including schizoaffective disorder, borderline personality disorder, and a history of substance dependency. The resident's service plan directed staff to manage polysubstance dependency by monitoring for and removing any drug paraphernalia, redirecting the resident when she feels the need to use substances, and providing engaging programs to prevent isolation and need for substance use.

Facility progress notes from the day of the incident indicated the resident was sleeping at the beginning of the evening shift, but when she woke up, she was talking and crying to herself. The notes indicated the resident was drinking liquor and called the police herself. The resident was taken to the hospital by ambulance.

Three days later, facility progress notes indicated facility staff reported the resident had been "drinking heavily over the weekend." The resident had started to cry and scream and then called 911 wanting to go to the hospital.

An ambulance report from the incident indicated paramedics responded to the facility due to a call to 911 from the resident. The ambulance report indicated upon arrival the resident, "appeared to be somewhat stressed, but is cooperative with the police officers and emergency medical services". The resident reported she was feeling depressed and wanted to be transported to the hospital via ambulance. The resident was taken to the hospital without incident.

Hospital notes from the evening of the incident indicated the resident reported using crack cocaine (an illegal narcotic) the previous evening and drank alcohol the day of the incident. The hospital staff spoke with the owner of the facility, who stated he did not think the resident was doing drugs at the facility, but the resident was able to come and go as she pleased.

A toxicology report from the resident's first day of hospitalization indicated the resident had cocaine and oxycodone (a narcotic used to treat pain) in her system.

During an interview, the facility administrator stated the resident had very challenging behaviors, including not taking her medications and calling 911 for non-emergent reasons. The administrator stated there was no illegal drug use in the home he was aware of, but the residents are free to come and go as they please. The administrator stated it was possible the resident was using illegal drugs in the facility because she had a lot of behaviors. The administrator stated if the residents have behaviors of slurred speech or the residents are not acting like themselves, the facility staff will send them to the hospital. The administrator stated the resident's service agreement was terminated due to the resident not taking her medications and her violent behaviors, which were causing other residents to leave the facility. The facility had given the resident notification of the termination of her contract with the facility 2 months previous to the incident and they were waiting for another facility to accept the resident so she could move. When the resident went to the hospital, the facility refused to take the resident back.

During an interview, the resident's case manager stated the resident had been having difficulty at the facility. The case manager stated the resident had a history of illegal drug use and informed the facility administration the resident was using illegal drugs in the home and having sexual relations with other residents, which is what the resident told her. The case manager stated the administrator told her the drug use was related to her mental illness and there was nothing they (the facility staff) could do to stop it. The case manager stated the resident went to a rehabilitation facility after hospitalization and is currently looking for a new permanent residence.

During interview an unlicensed staff stated the day the resident left the facility in an ambulance she had slept most of the day. The resident took a shower later in the afternoon and came into the kitchen to make coffee. The resident was talking to herself and told the staff she wanted to call the police because she had a toothache and needed to go to the hospital. The staff stated he suggested they call the dentist to make an appointment. The resident became angry and called the police. The police came and called an ambulance to take the resident to the emergency room.

During an interview, the resident stated she did illegal drugs in the facility. The resident stated there was a place in the basement of the facility the residents would go to do drugs. The resident stated she did not have any sexual relationship with any of the other residents in the facility.

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

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

“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: Yes
Family/Responsible Party interviewed: N/A- own responsible party
Alleged Perpetrator interviewed: NA

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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
Hennepin County Attorney

Brooklyn Center City Attorney
Brooklyn Center Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37090	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT PATH HOMES LLC	6800 QUAIL AVENUE NORTH 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 ******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: #HL370905742C/ #HL370908484M On January 30, 2024, 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 four residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL370905742C/#HL370908484M, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT PATH HOMES LLC	6800 QUAIL AVENUE NORTH BROOKLYN CENTER, MN 55429

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		