Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL37362007M
Compliance #: HL37362008C

Date Concluded: January 11, 2023

Name, Address, and County of Licensee Investigated:
Brooklyn Park Assisted Living
7719 Humboldt Ave N
Minneapolis, MN
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Yolanda Dawson, 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 facility neglected a resident when they failed to provide adequate services needed to prevent skin breakdown and promote wound healing.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the resident acquired a second pressure ulcer during his stay at the facility, it is unable to be determined if the pressure ulcer developed due to services not being provided by staff. Facility documentation supports care was provided in accordance with the resident's service plan. In addition, the resident received wound care services from an outside skilled nursing agency and the resident's pressure ulcers later healed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the agency wound care nurse. The investigation included review of resident records, agency wound care nurse notes,

and policies and procedures. During the onsite visit the investigator observed wound care and staff assisting with resident cares.

The resident resided in an assisted living facility. The resident's diagnoses included type 2 diabetes, difficulty speaking, right sided partial paralysis, communication deficit, and a buttock and left foot pressure ulcer. The resident's service plan included the resident received assistance with skin care, wound care, bed mobility, transfer assistance, and toileting assistance. The resident's assessment indicated the resident had areas of vulnerabilities to include limited range of motion, difficulty with transfers and walking, and communication difficulties. The resident's wound care was provided by an outside skilled nursing agency in addition to treatments provided by facility staff.

Wound care documents provided by the outside skilled nursing agency indicated care of the resident's heel pressure ulcer began in August 2021 and ended in March 2022, when the area healed. The outside agency nurse began providing care of the resident's buttock pressure ulcer in January 2022 through February 2022, indicating the buttock pressure ulcer developed during the time wound care was being provided by the outside agency.

The resident's record indicated staff provided care in accordance with the resident's service plan. Documentation identified staff turned and repositioned the resident every two hours while in bed and assisted the resident into a wheelchair in the morning. The resident's record also indicated wound care was provided by facility staff three times per day in addition to the visits made by the outside agency wound nurse.

Additional concerns identified in the complaint included concerns with the lack of activities being offered or provided to the resident. There was no documentation of the resident's attendance of activities and staff interviews indicated the resident declined to participate in activities.

During investigative interviews, multiple staff members stated participation in activities was based according to the resident's preferences. The staff members stated residents would often decline to participate in activities offered such as Bingo, movies, coloring, shopping, and walking outings. Staff members stated, at times, residents had to wait longer periods of time for assistance when the facility was short staffed, however, the residents always received required assistance.

During an interview, a facility nurse stated the resident admitted to the facility with the heel pressure ulcer and the buttocks ulcer developed during his stay at the facility. The nurse stated the resident was able to propel his wheelchair around the facility with one leg, but he preferred to be in his room. The nurse stated the facility was often short staffed and had more agency staff working than in-house staff. The nurse stated because of this, it was difficult to provide continuity of care. The nurse stated she was not aware of any concerns of the resident not

receiving proper care and the resident's wounds healed. The nurse stated the resident later moved to another facility to be closer to his family.

During an interview, a family member indicated concerns with the care provided at the facility. The family member stated staff did not provide activities for the resident and he sat in his room in front of the television all day long. The family member stated at one time she made a Zoom call to the resident at 11:30 a.m. and he was still in bed. The family member stated an agency nurse was caring for a wound on the resident's left heel, however she was unaware of the buttocks wound until after he moved to another facility.

During an interview, the agency wound care nurse stated she did not witness neglect of the resident. She stated he appeared well-groomed and would be up in his wheelchair when she arrived in the afternoon. The nurse indicated at one point she had to re-educate facility staff on the treatment required for the pressure ulcer on the resident's buttocks. After that training was provided, the wound healed. The nurse stated the foot wound took longer to heal but eventually closed and instructions were provided for staff to continue site care and monitoring of the area.

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

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, resident had difficulty speaking and moved to another facility.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
No further action taken at this time.

Action taken by the Minnesota Department of Health:

Insert appropriate action from standard language document

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
	37362	A. BUILDING: _____ B. WING _____	C 10/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKLYN PARK ASSISTED LIVING	7711 HUMBOLDT AVENUE NORTH 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 Initial comments On October 19, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL37362008C/#HL37362007M, #HL37362010C/#HL37362009M. No correction orders are issued.	0 000		