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 #: HL37362009M
Compliance #: HL37362010C

Date Concluded: January 11, 2023

Name, Address, and County of Licensee Investigated:
Brooklyn Park Assisted Living
7711 Humboldt Avenue North
Brooklyn Park, MN 55444
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Yolanda Dawson, RN
Special Investigator

Finding: Not Substantiated

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 the resident developed an ulcer on his buttocks.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility provided services in accordance with the resident's service plan. Staff responded appropriately to concerns regarding the resident's activity level and positioning and implemented interventions when skin integrity concerns were identified. Staff noted the resident had a red area on his buttock, but it did not progress to the next stage until he was hospitalized, and he returned to the facility with an open pressure ulcer. During the investigation, it was stated the pressure ulcer was being treated and was making progress in the healing process.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records,

assessment policies, and training policies. Also, the investigator observed wound care and staff members assisting with activities of daily living.

The resident resided in an assisted living facility. The resident's diagnoses included difficulty speaking, Asperger's syndrome, lack of coordination, left sided muscle weakness, unsteady gait, and blood vessel disease. The resident's service plan included assistance with transfers, mobility, therapeutic exercise, toileting, and skin care checks. The resident's assessment indicated due to history of a stroke and mental health diagnoses, the resident was unable to report abuse or neglect. Staff were directed to immediately report skin concerns due to the resident's chronic conditions.

The resident's record included documentation that staff turned and repositioned the resident every two hours while he was in bed. The record also indicated staff assisted the resident to a wheelchair at various times throughout the day. It was documented that staff provided therapeutic exercises in the morning; however, the resident did not always comply. Documentation further identified skin checks were completed by staff when assisting the resident with bathing and incontinent care.

During an interview, a staff member stated he reported to the nurse that the resident had the beginning of a wound on his backside, as the area was red. The nurse ordered cream that was applied to the area with each incontinence change.

A document from the agency that provided physical therapy, indicated staff should follow the following pressure ulcer prevention instructions: home care staff to assess pressure areas to identify any skin breakdown. If skin breakdown occurs, contact physician, and complete an incident report. Additionally assess/instruct patient and caregiver to keep skin clean and dry. Avoid scented soaps. Use skin moisturizer. Off-load every 15 minutes when sitting and at least every 2 hours when lying down. The document indicated the resident did not have a pressure ulcer at the start of therapy.

During an interview, a nurse stated she received a complaint from a family member that the resident was not getting out of bed enough. The nurse stated she responded by obtaining an order for occupational and physical therapy. The nurse stated the resident had a weeklong hospital stay and returned with an open pressure ulcer on his backside.

During an interview, a family member stated staff did not encourage the resident to get out of bed often enough. The family member stated there was an area on his buttock that was spongy and eventually opened during a hospital admission. The family member indicated there was now new management in place at the facility that were responsive to the resident's needs and the wound was healing.

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: Resident was hospitalized at time of investigation
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
None

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
	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		