Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL373628945M
Compliance #: HL373626542C

Date Concluded: March 20, 2024

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela R.N.
Special Investigator

Finding: Substantiated, individual responsibility

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 alleged perpetrator (AP) abused the resident when giving cares, the resident became involuntarily erect and the AP yelled at the resident telling him to calm it down and how gross it was. The AP then went into a community area to discuss the incident with other staff and residents present.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. Even though, there was a lack of evidence that the AP discussed the incident with others in a non-private location, there was a preponderance of evidence to show the AP treated the resident in a demeaning and humiliating manner while providing cares.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted form staff who were involved in the facility investigation. The investigation included review of the resident record(s), facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed facility campus and staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included a spinal cord injury, quadriplegic status and muscular cramps and spasms. The resident's service plan included assistance with activities of daily living (ADLs), transfers with a mechanical lift, urinary catheter care, range of motion (ROM) exercises, monitored anxious behaviors and daily safety checks. The resident's assessment indicated the resident was alert and orient.

A complaint document indicated that when the AP was giving cares to the resident, the resident had an involuntary erection. The AP responded to the resident by loudly telling the resident that it was gross and he needed to get control of himself. The resident then told the AP that he was not able to control the erection due to his condition. Afterward, the resident reported hearing the AP talking to other facility staff about the incident in a non-private location.

A facility investigation indicated the resident reported the incident involving the AP, while crying because he felt so humiliated and embarrassed about what had happened. The resident then explained concerns that other staff members observed him in vulnerable situations daily when he had no control of that part of his body. After interviews were completed with other unit staff, the facility investigation concluded that the AP spoke inappropriately to the resident and then loudly spoke of the incident, to other staff, in a non-private location, thereby, embarrassing him about an involuntary bodily action.

The resident's medical records indicated facility nursing staff did a follow-up interview with the resident two days after the incident. The resident informed the facility nursing staff that he felt very hurt by the incident and continued to be sad the next day. During the interview, the resident told the nursing staff that he did not want to repeat the conversation and wanted to put the incident behind him.

During an interview, facility management staff stated when the resident reported the incident, he said the AP made a big deal about the involuntary incident and told the resident it was disgusting. The resident then started to cry and said that he felt humiliated and embarrassed and in turn was uncomfortable being naked when having cares completed by other staff.

During an interview, facility administrative staff stated while interviewing the resident, the resident was crying while explaining the incident from his point of view.

During an interview, the resident stated while the AP was assisting with cares, the resident developed an involuntary erection which he believed may have been because due his body being tense because of a need to be reposition. The resident explained that it was common for his body to become tense when needing to be readjusted. After the resident became involuntarily erect, the resident stated the AP started yelling at him to control his body and to keep his mind off of things. The resident then stated the AP then admitted to him (the resident,) that she needed to yell at him because mind went elsewhere. The resident informed the AP that the erection was involuntary and that the AP did not need to yell at him because of the bodily spasm. The resident reported the incident to facility management staff as soon as his cares were completed by the AP. The resident stated during interview, the incident made him feel demeaned and during cares he felt he had to just turn his face, look at the wall and try to blacken everything out. The resident stated he felt belittled when trying to explain to the AP that a paraplegic person cannot control something like this from happening. The resident did not wish for the AP to give cares to him again after the incident. The resident could not recall if there were any witnesses to the incident.

In conclusion, the Minnesota Department of Health determined abuse was 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.
Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No. Resident responsible per self. Resident stated family members were unaware of the incident and preferred not to have them notified.
Alleged Perpetrator interviewed: No. Investigator attempted to reach-out to the AP five times, including by phone and email without response. The AP was subpoenaed …. .

Action taken by facility:
Completed a facility incident report.
AP no longer employed at facility.

Action taken by the Minnesota Department of Health:

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 Park Attorney
Brooklyn Park Police Department
County Attorney for county where incident occurred
City Attorney for city where incident occurred

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 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKLYN PARK ASSISTED LIVING	7711 HUMBOLDT AVENUE NORTH BROOKLYN PARK, MN 55444

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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: #HL373626542C/#HL373628945M #HL373629648C On February 29, 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 28 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL373626542C/#HL373628945M and #HL373629648C tag identification 1960 and 2350.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments	01960		

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01960	Continued From page 1 Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure treatments were administered as prescribed and failed to document when treatments were not administered as prescribed and any follow-up completed for one of one resident (R2) who required daily suprapubic catheter care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2's medical record indicated R2 admitted to the facility on November 11, 2022. R2's diagnoses included cerebral palsy, neuromuscular dysfunction of the bladder and personal history of urinary tract infection (UTI).	01960		

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01960	Continued From page 2 R2's service plan dated October 11, 2023, indicated the resident received assistance with personal cares, medication management, meals, behaviors, laundry, housekeeping, and transfer assistance. The service plan also indicated R2 received services for a licensed nurse to complete catheter care twice daily (bid). R2's nursing assessment/Individualized Abuse Prevention Plan (IAPP) dated January 19, 2024, indicated R2 was alert and oriented. The assessment indicated R2 was to receive catheter care BID (twice per day) including emptying the drainage bag, cleaning the site, cleaning the stoma, changing the catheter bag monthly and drainage bag according to the schedule. The assessment indicated R2 was noncompliant with the catheter treatment plan and had a history of UTIs. R2's nursing assessment did not include physician orders for catheter irrigation, when R2's catheter was to be irrigated, or by whom. R2's planned service document dated March 2024, indicated R2 received services for a licensed night nurse to irrigate R2's Foley Catheter with 20-30 cubic centimeters (cc) of normal saline per day to prevent the catheter from blocking with mucous. These instructions indicated the licensed nurse should notify the registered nurse if the flush was unsuccessful. The investigator requested R2's physician orders for Foley Catheter irrigation. Registered nurse (RN)-B did not provide R2's physician orders for this treatment. A complaint document dated January 25, 2023 at 10:40 a.m., indicated R2 was left without a nurse or nurse consultation for the last three days when her catheter was supposed to be flushed. The	01960		

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01960	Continued From page 3 complaint document indicated R2 had trouble with her catheter because no one had emptied her bag that had gotten backed up and caused R2 to have pain. R2 pressed her call light several times but no one answered, then called the facility's nurse phone line until she received some assistance. An incident report dated January 25, 2024, at 2:00 p.m. completed by registered nurse (RN)-B, indicated R2 reported that her catheter bag had not been emptied on a timely basis causing it to back-up during the night shift and there had been a lack of licensed nursing staff irrigating her catheter. The incident report indicated RN-B did not substantiate R2's complaint because, in addition to R2 having a history of refusing and postponing cares, on one occasion a night shift licensed nurse arrived a few hours late and completed R2's catheter irrigation sometime after her arrival. The licensee provided staffing schedule dated January 23, 2024, indicated a licensed nurse was not scheduled for the 6:45 p.m. to 7:00 a.m. shift on January 23, 2024 and for the date of January 24, 2024, there was not a nurse on-call. A review of R2's service delivery record dated January 23, 2024, indicated R2 received catheter care by the licensed nurse at 9:17 a.m., however it lacked indication that R2's catheter care had been completed by a licensed nurse at 8:00 p.m. RN-B provided an email on March 12, 2024 at 1:27 p.m., that indicated she (RN-B) was on-call for all weekends but the weekends she was on-call were not reflectied on the licensee's staffing schedule.	01960		

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01960	Continued From page 4 RN-B provided an email on March 14, 2024 at 4:17 p.m., that indicated LPN-H, came into work on January 23, 2024 at 12:30 a.m., however, LPN-H's initials were not on R2's treatment administration record (TAR) and there was no documentation that LPN-H was scheduled or worked on the licensee's provided staffing schedule for that date. RN-B provided an email on March 15, 2024 at 8:12 a.m., that indicated LPN-H informed RN-B, that it is routine for LPN-H to irrigate R2's catheter. LPN-H reported to RN-B that she irrigated the catheter but forgot to document that it was completed [no date of the forgotten documentation was provided]. RN-B provided an email on March 15, 2024 at 10:56 a.m., that indicated a nurse called-in on the evening/night shift of January 23, 2024 and January 24,2024. LPN-H picked-up the shifts and arrived a few hours late. RN-B had no knowledge that R2's catheter had not been irrigated that evening and also indicated that the irrigation could have been done any time during that night shift. RN-B indicated to have knowledge that a nurse was to cover the shift, and because the shift was covered, RN-B was not concerns with R2's care not being completed. In email correspondance on March 15, 2024 at 10:56 a.m., RN-B indicated that LPN-H was interviewed on January 25, 2024. The email indicated LPN-H approached R2 initially regarding catheter irrigation and R2 was not ready, LPN-H informed RN-B that R2 did agree to have her catheter irrigated at 1:45 a.m. [the date the catheter was irrigated at 1:45 p.m. was not provided]	01960		

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01960	Continued From page 5 R2's medical records did not include documentation that LPN-H completed a catheter irrigation at 1:45 a.m., between January 23, 2024 and January 25, 2024. In an email on March 18, 2024 at 1:21 p.m., RN-B indicated that on January 23, 2024, at 9:00 p.m., RN-B was the only nurse and was on-call for R2. The email indicated LPN-H arrived for her shift at the facility on January 24, 2024 at approximately 12: 30 a.m. The email indicated the facility's unsubstantiated incident report about R2's complaint regarding catheter care on January 23, 2024, would be changed and LPN-H would be educated regarding the lack of documentation of R2's catheter irrigation. During an interview on February 29, 2024 at 11:55 a.m., R2 stated one evening, her catheter bag leaking and was using her call pendent to call for assistance but no one came. R2 then called the licensee provided nurse line and was told by unlicensed personnel (ULP)-I, that there was not a nurse on duty but if there is an issue she (R2) could be transported to the hospital. R2 stated that after she called the nurse line astaff member arrived and changed her catheter bag. R2 did not know what time this occurred. R2 stated her catheter was usually emptied around 11:00 p.m. to 12:00 a.m. but recalled that her catheter bag was not been emptied the night of January 25, 2024. R2 stated that sometimes she (R2) refused to have her catheter flushed when she feels it is not needed. R2 also felt catheter care was not always completed on the night shift because staff think she is asleep. During an interview on March 6, 2024 at 2:03pm, LALD-A stated licensed nurses were on-site twenty-four hours per day, seven days per week.	01960		

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01960	Continued From page 6 LALD-A indicated licensed nurses could answer call lights and all residents were provided with contact information to the nurse phone line. LALD-A stated residents were given the nurse line phone contact upon admission. LALD-A provided the licensee's Resident Handbook that included RN-B's phone contact and email, however, it did not indicate RN-B's on-call status. During an interview on March 11, 2024 at 10:03 a.m., R2's case manager/social worker (SW)-E, stated she recieved a voice message from R2 on January 25, 2024 at 12:00 a.m., that indicated R2 had staffing concern. SW-E stated R2 reported that her catheter bag did not get cleaned. SW-E then contacted RN-B who informed her that the RN who was on-call at night and during the past three nights prior to the incident called in sick, and the nurse covering was late to the shift, but that R2's catheter had been irrigated but not as quickly as R2 would have liked. During an interview on March 11, 2024 at 11:34 a.m., RN-B stated to the best of her knowledge R2's catheter had never broken. RN-B stated around the time of the incident, a nurse had been running late to start the night shift which was 6:45 p.m. to 7:00 a.m. RN-B stated LPN-H was a few hours late on January 23, 2024. RN-B stated she (RN-B), was the on-call nurse until LPH-H showed for her shift (January 23, 2024). RN-B stated that she did not recall R2 calling her (RN-B) or any other nurse but that R2 had her cellular phone number and had called her (RN-B) in the past. A licensee provided policy dated September 23, 2020, Titled: Medication and Treatment Orders indicated under section: Procedures (1) The RN is responsible for assuring the orders for	01960		

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01960	Continued From page 7 treatments are being retained in the resident's record and being communicated to staff to ensure the prescribed treatments are being administered per provider's orders. An undated licensee provided policy titled Medication and Treatment Documentation indicated all medications and treatments must be documented correctly before you clock out for the day to ensure resident care is being done per the service agreement of each resident. If documentation of services is not completed on your shift, corrective action would be taken. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02350 SS=G	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on interview and record review, an unlicensed personnel, (ULP)-C, failed to treat a resident (R-1) with courtesy and respect when providing cares. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	02350		

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02350	Continued From page 8 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on June 13, 2019, with the diagnoses of spinal cord injury, quadriplegia, muscular cramps and spasms. R1's service plan dated March 25, 2022, indicated R1 received daily services for staff assistance with activities of daily living such as, grooming, dressing, therapeutic exercise, hand splint, monitored anxious behaviors, safety checks and a urinary catheter. The service plan indicated R1 received assistance from two staff for all transfers and a mechanical lift. R1's nursing assessment dated August 7, 2023, indicated R1 was alert and oriented, R1 self-administered medications after weekly nurse set-up, received range of motion exercises (ROM) twice a day with staff assistance, had a history of skin breakdown in perineal area and used bedrails for bed mobility. R1's unsigned Service Plan dated October 11, 2023, indicated R1 received the Assisted Living Resident Bill of Rights Document. A Grievance Form dated October 10, 2023, at 12:00 p.m., indicated while unlicensed personnel (ULP)-C was providing cares R1 had an erection. ULP-C told R1 that it made her uncomfortable and R1 needs to calm down. ULP-C proceeded to go to a common area and discuss the incident with other staff in front of other residents which made R1 feel humiliated and embarrassed. The grievance form indicated R1 started to cry during administrative staff's interview and that he was	02350		

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02350	Continued From page 9 embarrassed. The grievance form indicated the licensee found ULP-C was inappropriate to R1 and furthered the incident by discussing the incident in a non-private area. R1's progress notes dated October 12, 2023, at 3:47 p.m., by registered nurse, (RN)-B, indicated R1 was checked on by RN-B to see how he was feeling emotionally. R1 told RN-B that he had been feeling sad yesterday but much better today, but the conversation heard from a staff on dayshift really hurt his feeling and had hoped the conversation would not be repeated. R1 stated he was fine and had put the incident behind him. An email dated March 12, 2024 at 12:56 p.m., by the licensed assisted living director (interim), (LALD)-A, included that an incident report was completed, however, due to staff transition, the licensee was unable to determine where the incident investigative interviews were located. During an interview on March 12, 2024 at 9:03 a.m., the former assisted living director in training, (ALD)- D, who completed and reviewed R1's grievance document on October 10, 2023 at 12:00 p.m., stated ULP-C admitted to stating the remark to R1 regarding R1 having to control himself during cares. ALD-D stated R1 was upset and crying during the facility investigative interview. During an interview on March 12, 2024 at 11:03 a.m., R1 stated while ULP-C was assisting R1 to get up out of bed, R1 had an uncontrollable erection and explained that it was not unusual for his body to tense up after laying in one position so long. R1 stated ULP-C started yelling at him (R1) to control his body when R1 told ULP-C that his muscles do that uncontrollably. R1 stated	02350		

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 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKLYN PARK ASSISTED LIVING	7711 HUMBOLDT AVENUE NORTH BROOKLYN PARK, MN 55444

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02350	Continued From page 10 ULP-C then told R1 to keep his mind off of things, then told R1 that she had to yell at him because his mind went elsewhere. R1 stated he informed ULP-C immediately that she did not have to yell that his muscles had spasmed. R1 then stated he went right to the office to report it to RN-B and administrative personnel, (ADM)-R. R1 stated feeling demeaned and belittled during the incident and turned his face away, looked at the wall and attempted to black the incident out. R1 stated he was uncomfortable having ULP-C working with him again and requested ULP-C be assigned to another unit. During an interview on March 13, 2024 at 3:02 p.m, the director of operations, (ADM)-R, stated R1 reported to her that when he was having cares completed by ULP-C, he had an involuntary erection. R1 reported that after the incident ULP-C made a big deal of it, told R1 it was disgusting and also informed R1 how uncomfortable it made her (ULP)-C feel. Then ULP-C went out into the common area to tell staff about the incident. ADM-R stated R1 was crying as he reported the incident and told her (ADM)-R that ULP-C made him feel embarrassed, humiliated, he did not have control over that occurring and felt uncomfortable being naked when having cares completed. The licensee provided Orientation and Training Competencies dated February 1, 2024, indicated all unlicensed staff would be trained and competent in areas of: 1. (a) provisions to assure resident would receive appropriate treatment while respecting individual autonomy and choice. (l) provisions to enforce these regulations and the assisted living bill of rights. The licensee provided Bill of Rights for the	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02350	Continued From page 11 Assisted Living Residents dated, August 1, 2022, indicated under Applicability: (4) Courteous treatment: Residents had the right to be treated with courtesy and respect, (5) Freedom from Maltreatment: Residents have the right to be free from physical and emotional abuse; and all forms of maltreatment covered under the Vulnerable Adult Act. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (7) days	02350		