Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL379537364M
Compliance #: HL379533982C

Date Concluded: May 1, 2024

Name, Address, and County of Licensee Investigated:

Victory Homes
7917 Perry Ave N
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Yolanda Dawson, RN
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 they did not implement interventions to address the resident refusing medications, leaving the facility without notifying staff, and possible substance abuse.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Despite numerous attempts at redirection by facility staff, the resident continued to refuse medications, physician appointments, and continued to leave the facility without signing out as directed by staff.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's mental health care coordinator and the ombudsman. The investigation included review of employee and resident records. Also, the investigator observed medication administration and storage.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder, bipolar disorder, post-traumatic stress disorder, and polysubstance abuse. The resident's service plan included assistance with medication management, safety checks, and behavior monitoring. The resident was not at risk for elopement, wandering, or self-abuse.

Documentation indicated the resident was verbally aggressive with staff and noncompliant with medication administration. The documentation also indicated staff asked the resident to sign out when leaving the facility and he refused. It was documented that the resident would often leave the facility without communicating with staff; at times the resident returned the same day and other times he would be gone several days. Despite several attempts to schedule a provider appointment with the resident's physician, the resident refused or left the facility without staff awareness, missing the appointment. Instead, the resident chose to be evaluated several times a month in a hospital emergency room and not follow through with provider appointments for medication refills. When the resident could not be found, staff attempted to contact the resident through his cell phone which the resident often shut off or contacted the resident's family. On more than one occasion, staff went out in the community to find the resident.

During an interview, the nurse stated the resident was noncompliant with medication administration. The nurse stated the resident would come and go but he would come back.

During an interview, the administrator stated the resident did not comply with house rules. The resident did not sign in and out when leaving and did not notify staff when he would not be returning. Because of this, staff did not have the opportunity to prepare his medications to take with him. The administrator stated law enforcement would be called if the resident did not return within 24 hours.

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, attempt unsuccessful.
Family/Responsible Party interviewed: No, attempt unsuccessful.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
Sign out book provided for resident to communicate when he was leaving and when he would return. Eviction warning given to resident. Facility communicated resident behavior to case manager.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37953	A. BUILDING: _____ B. WING _____	C 02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY HOMES	7917 PERRY AVENUE NORTH BROOKLYN PARK, MN 55443

(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 February 27, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL379533982C/#HL379537364M. No correction orders are issued.	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.	