Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL387035124M
Compliance #: HL387038822C

Date Concluded: April 11, 2023

Name, Address, and County of Licensee Investigated:
Berkeley Heights Homes
6308 65th Avenue North
Brooklyn Park, MN, 55428
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, 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 failed to provide supervision to the resident. The resident left the facility for an extended period which resulted in the resident receiving frostbite injuries to his foot.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility asked the resident not to leave because the temperature was cold outside, the resident left the facility, on his own accord, and returned the following day. Once staff noticed the resident's skin injuries, they coordinated care in a timely manner.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records, employee files, internal investigations, incident reports, and facility policies. The investigator

contacted the hospital social worker. Also, the investigator toured the facility and observed the facility environment.

The resident resided in an assisted living facility. The resident's diagnoses included depression, obsessive compulsive disorder (OCD), attention deficit hyperactivity disorder (ADHD), and Asperger's syndrome. The resident's service plan included assistance with housekeeping, medication management, meals, and laundry. The resident required daily safety checks and behavior management. The resident's nursing assessment indicated he was alert, orientated, and able to communicate his needs. The resident required reminders for bathing and grooming, but he was able to provide most of his physical care needs independently. The resident walked independently without the use of a device.

Progress notes indicated the resident left the facility late in the evening and returned mid-morning the following day. The notes indicated caregivers asked the resident to remain at the facility because it was cold outside, however the resident said he was meeting a friend and it was an emergency. When the resident returned, caregivers smelled alcohol on him and noticed he was talking to himself but did not notice any physical injuries. The following day the resident told caregivers his feet hurt. Caregivers checked his feet and observed frostbite injuries. Caregivers coordinated care and sent the resident to the hospital for treatment.

Hospital records indicated a physician treated the resident for frostbite injuries of his right foot and ordered him to go to a burn clinic for further care. The physician discharged the resident back to the facility. After the initial physician evaluation, the resident went to the appointment at the burn clinic, but he was aggressive and required removal from the burn clinic. The resident returned to the hospital for treatment and physicians treated him four times in less than three weeks. Also, the resident received treatment from a physician at another burn clinic. The resident insisted his toe required amputation and eventually began to stick sharp objects into necrotic tissue (dead skin). He continued to go in and out of the hospital for care, and eventually physicians admitted him into the hospital after responders found him intoxicated, lying in a snowbank.

During an interview, a manager said the resident's behavior became more erratic over the last couple of months due to his increased alcohol consumption. The manager said the resident would not follow physician orders for treatment of his frostbite injuries. The manager said she reached out to multiple community resources to help coordinate mental health care for the resident. The manager said the resident remained at the hospital and there were no plans for the resident to return to the facility.

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:
(a) 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. At hospital.
Family/Responsible Party interviewed: No. Not Applicable.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility sent the resident to the hospital once injuries were discovered and contacted multiple agencies to coordinate mental health care.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment. 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
Or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

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
	38703	A. BUILDING: _____ B. WING _____	C 04/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOMES LLC	6308 65TH 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 LICENSING 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: #HL387038822C/#HL387035124M On April 3, 2023, 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 3 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL387038822C/#HL387035124M, tag identification 2310.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted	02310		

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02310	Continued From page 1 living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain parameters for medication administration while the resident was under the influence of alcohol for one of one resident (R1) with records reviewed. 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: R1 admitted to licensee on September 2, 2022, and received services for diagnoses that included bipolar disorder, ADHD, OCD, major depressive disorder, and anxiety. R1's service plan dated September 2, 2022, indicated he received assistance with medication management, housekeeping, laundry, and meals. The service plan indicated R1 received reminders and cueing for grooming and hygiene. R1 received daily behavior management and safety checks. R1's admission assessment dated September 2, 2022, indicated R1 used alcohol 4-5 times per	02310		

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02310	Continued From page 2 week and had a history of being hospitalized for alcohol intoxication. R1's medication list dated February 1, 2023, through February 28, 2023, contained the following orders: Diazepam 5 mg take ½ tablet every morning Citalopram 40 mg take 1 tablet daily Topiramate 50 mg take 1 tablet twice a day Adderall XR 30mg take 1 capsule every morning Diazepam 5 mg take 1 tablet at bedtime Quetiapine 100mg take 1 tablet at bedtime R1's progress notes dated February 1, 2023, through February 28, 2023, indicated unlicensed personnel (ULP) found alcohol bottles in R1's room. The dates as follows: February 1, 2023 February 2, 2023 February 7, 2023 February 9, 2023 February 10, 2023 February 19, 2023 R1's progress notes dated February 1, 2023, through February 28, 2023, indicated unlicensed personnel (ULP) found hand sanitizer in R1's room. The dates as follows: February 15, 2023 February 16, 2023 February 20, 2023 Medication administration example: Progress notes dated February 3, 2023, indicated "[R1's] breath smelled like alcohol." Staff gave him his morning medication, but R1 refused . R1's progress note dated February 9, 2023,	02310		

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02310	Continued From page 3 indicated staff administered morning medication. Staff called 911 because R1 complained of foot pain. R1 yelled and screamed at staff. Staff then found an empty alcohol bottle in R1's room. R1's progress note dated February 19, 2023, 7 a.m. to 3 p.m., indicated staff observed R1 sleeping "with a liquor bottle in his chest." "Client took his meds." R1's progress note dated February 20, 2023, indicated staff found two empty hand sanitizer bottles in R1's room and wrote "could smell hand sanitizer on [R1's] breath." During an interview on April 6, 2023, at 3:29 p.m., registered nurse (RN-A) said she did not report R1's alcohol consumption to his primary physician. RN-A said she called Hennepin County mobile crisis response team (COPE) and R1's position support analyst (PSA). RN-A acknowledged the support teams were not physicians. Licensee's, Medication Management Program, dated 2021, indicated licensee would coordinate and communicate with the prescriber. Licensee's, Service Plan for Medication Management, dated August 1, 2021, indicated licensee would monitor medication use to prevent possible complications or adverse reactions. TIME PERIOD OF CORRECTION: Seven (7) Days	02310		