Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL364693764M
Compliance #: HL364694707C

Date Concluded: November 30, 2022

Name, Address, and County of Licensee Investigated:
Berkeley Heights Homes LLC
3957 Wisconsin Avenue North
New Hope, MN 55427
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Maerin Renee, RN, Special Investigator
Katie Germann, 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 the facility would not allow the resident to return after a hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The facility initially failed to allow the resident to return after she was hospitalized, without appropriate notice of termination. However, while in the hospital, the resident told staff she did not want to return to the facility.

The investigators conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigators contacted the resident's case

managers. The investigation included review of the resident charts and hospital records, policies and procedures, and discharge notices.

The resident resided in an assisted living facility. The resident's diagnoses included traumatic brain injury, adjustment disorder, mild depressive disorder, and chronic pain. The resident's service plan included assistance with medication management, activities of daily living, safety checks, and help with appointments.

During interview, an administrator stated the facility made the decision not to accept the resident back from the hospital because they could not manage her escalating, unsafe behaviors. The administrator stated the resident caused extensive property destruction, and they deemed the resident a danger to herself and others. The leadership team decided the resident's behaviors could not be managed properly at the facility and expected the resident's case worker to find a new placement for her.

When interviewed, a case worker stated the hospital attempted to discharge the resident back to the facility but were told the facility would not accept the resident back. While attempting to resolve the situation, hospital staff discovered the resident had left the hospital without notifying hospital staff prior to discharge.

A review of hospital records indicated the resident stated she did not want to return to the facility and instead wanted to take up residence with her boyfriend. The resident left the hospital, prior to being discharged, without notifying hospital staff.

Multiple attempts were made to contact the resident but were unsuccessful.

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. The resident did not answer calls, and the phone was unable to accept messages.
Family/Responsible Party interviewed: No, the resident is her own guardian.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action taken.

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 651-201-4890 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
	36469	A. BUILDING: _____ B. WING _____	C 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOMES LLC	1808 MEADOWWOOD COURT 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 ******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: HL364693764M/HL364696302C On September 28, 2022, 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 four (4) residents receiving services under the provider's Assisted Living license. The following correction orders are issued for HL364693764M/HL364696302C, tag identification 1040 and 1070.	0 000	The Minnesota Department of Health documents the State Licensing 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	
01040 SS=D	144G.52 Subd. 7 Notice of contract termination required	01040		

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01040	Continued From page 1 (a) A facility terminating a contract must issue a written notice of termination according to this section. The facility must also send a copy of the termination notice to the Office of Ombudsman for Long-Term Care and, for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5. (b) A facility terminating a contract under subdivision 3 or 4 must provide a written termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative. (c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal representative, and designated representative. (d) If a resident moves out of a facility or cancels services received from the facility, nothing in this section prohibits a facility from enforcing against the resident any notice periods with which the resident must comply under the assisted living contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to issue a written notice for a termination of contract at least 30 days ahead of the termination, or at least 15 days ahead of an expedited termination, and failed to provide documentation supporting the need for an expedited termination of their contracts for one of one resident (R1) with records reviewed. After R1	01040		

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01040	Continued From page 2 was hospitalized, R1's contract was terminated without notice and she was not allowed to return to the facility. In addition, the facility failed to send a copy of the termination notice to the Office of Ombudsman for Long Term 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) 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 was admitted to the facility on February 1, 2022. R1's diagnoses included traumatic brain injury, adjustment disorder, chronic pain, mild depressive disorder. R1's service plan dated April 1, 2022, indicated R1 received services for medication management, activities of daily living, reminders, safety checks, and assistance to get to appointments. Review of R1's progress notes dated July 13, 2022, indicated R1 was sent to the hospital for further evaluation of escalating mental health behaviors and destruction of property. After R1 was stabilized, hospital staff called the facility to coordinate discharge planning. At that time, facility staff informed the hospital that R1 would not be allowed to return to the facility. R1's record lacked evidence R1 received a written termination notice.	01040		

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01040	Continued From page 3 R1's record lacked evidence that a copy of the termination notice was sent to the Office of Ombudsman for Long-term Care. R1's record lacked documentation supporting the need for an expedited termination of R1's contract. On September 30, 2022, at 1:00 p.m., the licensed assisted living director (LALD)-A stated when R1 was hospitalized, facility administration decided to not let R1 return to the because staff could not properly manage her behaviors. LALD-A verbalized the expectation that R1's county caseworker would manage R1's housing needs going forward. A facility policy titled "Discharge and Transfer of Residents" dated August 1, 2021, indicated the facility would not refuse to allow a resident to return if a termination of housing had not been implemented. TIME PERIOD TO CORRECT: Twenty one (21) days.	01040		
01070 SS=D	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to allow the return of one of one resident	01070		

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01070	Continued From page 4 (R1) after a hospitalization. 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) 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). Findings include: R1 was admitted to the facility on February 1, 2022. R1's diagnoses included traumatic brain injury, adjustment disorder, chronic pain, mild depressive disorder. R1's service plan dated April 1, 2022, indicated R1 received services for medication management, activities of daily living, reminders, safety checks, and assistance to get to appointments. Review of R1's progress notes dated July 13, 2022, indicated R1 was sent to the hospital for further evaluation of escalating mental health behaviors and destruction of property. Hospital records dated July 13, 2022, R1 presented in the emergency room for behavioral disturbance at her assisted living facility. R1 was assessed by emergency room staff, and it was determined she was stable enough to be discharged back home. Hospital staff contacted the facility for discharge planning, and the facility representative stated R1 would not be allowed to return to the facility. On October 3, 2022, R1's case manager (CM)-D	01070		

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01070	Continued From page 5 stated the hospital attempted to discharge R1 on July 13, 2022. At that time, the facility said they would not accept R1 back at the facility and CM-D would need to find her a home. On September 30, 2022, at 1:00 p.m., licensed assisted living director (LALD)-A confirmed that the facility made the decision not to accept the resident back from the hospital because they could not manage her behaviors. R1's record lacked evidence the facility issued a written notice of termination of services. A facility policy titled "Discharge and Transfer of Residents" dated August 1, 2021, indicated the facility would not refuse to allow a resident to return if a termination of housing had not been implemented. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	01070		