Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL391441802M
Compliance #: HL391442833C

Date Concluded: May 5, 2025

Name, Address, and County of Licensee Investigated:
Compass Assisted Living
7100 64th Avenue North
Brooklyn Park, MN 55428
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, 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: The facility neglected the resident when the resident was suspected of smoking and a fire started in her room. Residents had to be evacuated from the house and the resident was moved to a different room due to the fire and smoke damage.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility had smoking policies in place prior to the fire which the resident had agreed to, performed assessments and added safety measures related to smoking practices with the resident post incident. The final fire report did not indicate the fire was directly caused by smoking activity.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case worker. The investigation included review of the resident record, hospital records, facility video camera footage, facility incident reports, staff schedules, related facility policy and procedures and the

city fire report. The investigator observed interactions between residents and staff during a visit to the facility.

The resident resided in an assisted living facility. The resident's diagnoses included chronic obstructive pulmonary disease (lung and breathing), schizophrenia and diabetes. The resident's service plan included assistance with medications and reminders with basic activities of daily living. The resident's assessment indicated she could manage her own transportation and could make her needs known. The assessment also indicated she was a smoker and had signed and acknowledged the facility's smoking policy.

One morning a fire started in the resident's room. The resident along with the other residents living in the facility were evacuated, and the fire was put out with a fire extinguisher before the fire department arrived. At the source of the fire, the fire department removed the television that was sitting on top of a dresser and part of the wall to make sure the fire had not spread to any other room.

The resident signed a smoking intervention plan after the incident. The plan acknowledged that smoking was prohibited inside the facility, rooms would be inspected regularly for smoking-related hazards and staff were to ensure cigarettes and lighters would be collected each time the resident entered the facility.

During an interview, a nurse stated a smoking assessment was completed after fire incident and determined the resident was not a safe smoker. The nurse stated the assessment concluded the resident needed supervision while smoking and staff members were to store her lighters and cigarettes during the times she was in the house.

During an interview, a case manager stated the facility has worked with the resident to develop contracts and has added additional staff to help with supervision.

During interview, the resident denied the fire was caused by her smoking and stated the cause was the television exploded.

The city fire inspection report concluded the fire was undetermined but based on the burn patterns, combustibles (miscellaneous items) on top of the dresser were ignited by an undetermined heat source but suspected to be a lighter that had heat damage on one side. The television was ruled out as a heat source.

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: Yes.
Family/Responsible Party interviewed: No.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: The facility management repeated fire training and the evacuation plan with residents and staff. They also added an additional fire extinguisher that was in a clearly visible area.

Action taken by the Minnesota Department of Health: No further action 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
	39144	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASS ASSISTED LIVING LLC	7100 64TH AVENUE NORTH BROOKLYN PARK, MN 55428

(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 April 23, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL391442833C/#HL391441802M. No correction orders are issued.	0 000		