Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303005583M
Compliance #: HL303009678C

Date Concluded: July 18, 2023

Name, Address, and County of Licensee Investigated:
Brookside Assisted Living
2729 State 371 Southwest
Pine River, MN 56474
Cass County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Carol Moroney RN,
Special Investigator
Rhylee Gilb, 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 residents (resident 1, resident 2, resident 3, resident 4 and resident 5), when resident 5 was allowed to expose private body parts, fondle other residents, and potentially had sex with other residents.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Resident 5 did go into other resident's rooms; however, the facility identified it immediately and applied an alarm on resident 5's door to identify when the door was opened. The unlicensed personnel (ULP) were aware of resident 5's behaviors and interventions. The ULP monitored resident 5's whereabouts with one-to-one supervision when not in his room.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted families of the residents. The investigation included review of in-patient psychiatric health records, mobile crisis unit visits, psychiatric visits notes, primary care clinic visits, provider orders, and facility resident records. The investigator observed resident 1, resident 2, resident 3, and resident 4. Resident 5 was unavailable to observed.

All five residents resided in an assisted living facility. Resident 1 had a diagnosis of dementia and was able to walk. She had a history of wandering, was oriented but forgetful. Resident 1's service plan indicated she required assistance with dressing and grooming.

Resident 2 had a diagnosis of dementia. Resident 2 was unable to walk. Resident 2's impaired cognition allowed for her to only answer yes or no questions. Resident 2's service plan indicated she required assistance with dressing, grooming, toileting, repositioning and with eating.

Resident 3 had a diagnosis of dementia. Resident 3's cognition was moderately impaired. Resident 3's service plan indicated she required assistance with walking, dressing, grooming, escorts, and toileting reminders.

Resident 4 had a diagnosis of dementia. Resident 4's was usually oriented but got confused and forgetful. Resident 4 used a four-wheel walker to walk with stand by assistance of staff. Resident 4's service plan indicated she required assistance with dressing, bathing, and toileting reminders.

Resident 5's diagnoses included traumatic brain injury, hallucinations, and other psychiatric diagnoses. Resident 5 had severely impaired cognition with a history of aggressive, violent, and sexually inappropriate behaviors. Resident 5 had several emergency room visits for psychiatric behaviors including smashing his window with his guitar, attempting to elope and a catatonic (fixed, non-responsive) episode. Resident 5 required several antipsychotic and antidepressant medication changes to control his behaviors.

A facility internal investigation indicated an incident when resident 5 wandered into resident 2's room. Resident 5 was found in resident 2's bed. Staff removed resident 5 from the room and five minutes later he wandered back into resident 2's room and was found in her bed with his hand resting on top of her clothed pajama bottoms. Staff removed resident 5 from resident 2's room again. The registered nurse (RN) implemented a door alarm on resident 5's room to alert staff when he was leaving his room and hourly safety checks on resident 5 to monitor his whereabouts.

Another facility internal investigation indicated staff reported several incidents. One incident, resident 5 wandered into resident 1's room and defected on the floor. There was not evidence resident 5 had touched resident 1. Another incident, resident 5 wandered into resident 4's room, laid on her bed and opened his robe. Resident 4 denied resident 5 touching her. A third

incident, resident 5 wandered into resident 3's room. Resident 3 was in her bathroom and yelled when she saw resident 5 to get out of her room.
After the incidents, resident 5 was placed on 1:1 staff monitoring, and additional medication changes occurred. In addition, due to resident 5's extreme behaviors despite interventions and medication changes, the facility initiated the discharge process for resident 5 to move to a more suitable facility to handle his behaviors with a less vulnerable population.

During investigative interviews, multiple staff members stated resident 5 was confused and unaware of his actions at times. When resident 5 wandered into other residents' rooms, staff removed resident 5 immediately. The staff indicated they were educated on resident 5's behaviors and interventions. The staff verbalized an understanding of what the expectations were to ensure safety for all residents.

During an interview with the RN, she stated resident 5 had escalating behaviors and disrobing throughout the facility. The RN stated they utilized the mobile crisis unit three times and sent him to the emergency room as well. The RN stated he was followed by psychiatry and his physician made several medication changes. The RN stated resident 5 hallucinated and would speak to himself and indicated he could hear voices telling him to do things. He had an alarm on his window and door. The RN stated when they sent him to the hospital, the hospital would state they did not see his behaviors and send him back. When his behaviors continued to escalate the began the discharge process meeting with family and the ombudsman to find him more suitable placement.

During interviews with resident 1, resident 2, resident 3 and resident 4, they all reported their care was good and had no complaints.

In conclusion, the Minnesota Department of Health determined neglect as 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: Yes.

Family/Responsible Party interviewed: Yes, resident 2 and resident 5's family.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility investigated the incidents, developed a plan and implemented increased monitoring of resident 5, medication changes and a door alarm. The facility trained staff to monitor resident 5 and implement safety interventions.

Action taken by the Minnesota Department of Health:
No further action taken 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
	30300	A. BUILDING: _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE ASSISTED LIVING	2729 STATE 371 SW PINE RIVER, MN 56474

(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 July 6,2023, the Minnesota Department of Health initiated an investigation of complaint #H303009678C/HL303005583M. 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 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.	