Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL364699525M
Compliance #: HL364697327C

Date Concluded: May 16, 2024

Name, Address, and County of Licensee Investigated:
Berkeley Heights Homes
1808 South Meadowood Court
Brooklyn Park, MN 55444
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Katie Germann, RN, Special Investigator

Finding: Substantiated, facility responsibility

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 to provide appropriate supervision to the resident. The resident was found deceased in her room from a drug overdose.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility documented an extensive history of the resident's drug use and prior overdose. The facility failed to implement interventions to ensure the residents safety. The resident was found deceased in her room from a drug overdose.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator contacted the medical examiner. The investigation included review of medical records, staff charting, policies and procedures, and the medical examiner report.

The resident resided in an assisted living facility. The resident's diagnoses included bipolar disorder, anxiety, and depression. The resident's service plan included assistance with housekeeping, medication management, transportation, and meals. The resident's assessment indicated the resident had a history of smoking in her room and substance abuse leading to hospitalizations.

A facility incident report indicated the resident had not come out of her room one evening from approximately 4:00 p.m. to 10:45 p.m. A facility unlicensed staff checked on the resident and stated the resident was sleeping in her bed. Approximately 25 minutes after the last safety check, the unlicensed staff could hear the resident in her room and went to check on her. The resident was last seen awake in her room at approximately 11:30 p.m. The next morning, another unlicensed staff waited for the resident to come out of her room for her morning medication. When the resident didn't come out, the unlicensed staff knocked on the door at 9:00 a.m. but the resident didn't answer. The staff unlock the resident's door and found the resident deceased laying in her bed.

The facility progress notes from the day prior to the incident indicated the resident was seen in her room awake at 11:37 p.m. The next progress note indicated the resident's family arrived at the facility in the afternoon and found the resident's boyfriend asleep in the closet. Facility staff asked him how he got into the facility, but he did not answer.

The medical examiner's report indicated the resident was found mid-morning at the facility. The resident had passed away due to a fentanyl (a narcotic pain medication) and methamphetamine (a narcotic stimulant) overdose.

A facility document titled "Assisted Living Contract Addendum" dated over a year prior to the incident, indicated the facility had concerns with the resident's unsafe activities including substance abuse. The document indicated the facility would have a zero tolerance for drug use or bringing drug paraphernalia in the home. The document indicated the resident's boyfriend would only visit during business hours and would not be allowed to come to the facility overnight or in and out the resident's window.

A facility document dated three months prior to the resident passing indicated the facility staff met with the resident and her case worker to discuss the resident's repeated hospitalizations resulting from her drug use. The plan of action indicated the facility staff would monitor the resident in the community by calling her cell phone and if they could not reach her, they could call the police to file a missing person report. The document indicated the resident would be expected pay her rent instead of spending her money on drugs, and the resident would be allowed to have her boyfriend over, but only during visiting hours and only through the front door.

During an interview, the facility administrator stated staff informed him around 9:30 a.m. the resident was unresponsive in her bed and staff were instructed to call 911. The administrator

stated he was told the resident came in the night before around 4:30 p.m. and went into her room. Staff attempted to check on her around 8:00 p.m. but the resident blocked her door from the inside. The resident told the staff she did not want to be bothered until the next day. The overnight aide also had difficulty opening her door because the resident had blocked it from the inside. The morning staff was able to open the door and found the resident unresponsive. The administrator stated the resident had a history of receiving her monthly check and the resident's boyfriend would come and take her to buy drugs. The resident would overdose and go to the hospital, and she would not have money to pay her rent. The administrator stated the staff had meetings about the resident's drug use and the resident was "encouraged" to not use drugs.

During an interview, the resident's family member stated they arrived at the facility to collect the residents' belongings on the same day the resident passed away. When they were in the room, they stated there was drug paraphernalia all over the room including, aluminum foil rolls, some burnt aluminum foil, pens, and lighters. The family member stated when they opened the closet the resident's boyfriend was asleep sitting in the litter box. The family member stated the boyfriend asked where the resident was, and they informed him the resident had passed away. The resident's boyfriend said, "okay" and left the room.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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, resident passed away.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

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
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department

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 04/18/2024

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 ******ATTENTION****** ASSISTED LIVING PROVIDER 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: #HL364697327C/#HL364699525M On April 18, 2024, 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 #HL364697327C/#HL364699525M, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No Plan of Correction is required for this tag.	02360		