Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL368524244M
Compliance #: HL368527180C

Date Concluded: November 16, 2023

Name, Address, and County of Licensee Investigated:
Berkeley Heights Homes LLC
1509 Sugarloaf Trail
Brooklyn Park MN 55444
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela, R.N.
Special Investigator

Finding: Not Substantiated

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 Resident #1 and Resident #2 when they failed to follow up on the resident's reports of being sexually assaulted by Resident #3.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Information provided identified Resident #1 was not a resident of the facility but was a visitor of Resident #3. The visitor initially reported to staff they were sexually assaulted by Resident #3, however refused to provide details, or pursue further investigation into the incident. The visitor was unable to be contacted for interview regarding the allegation and there was no additional contact information available for this individual. Resident #2 denied being sexually assaulted by Resident #3.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement. The investigation included review of medical records, facility documentation, and facility policies

and procedures. In addition, the investigator observed staff interaction and communication with residents and medication administration at the time of the onsite visit.

Resident #2 resided in an assisted living facility. Resident #2's diagnoses included schizophrenia and schizoaffective disorder. Resident #2's service plan included assistance with meal preparation, housekeeping, laundry, meal preparation, medication management, and behavior monitoring. Resident #2's nursing assessment included a history of anxiety and prescribed anti-psychotropic medication.

Resident #3 resided in an assisted living facility. Resident #3's diagnoses included schizophrenia and schizoaffective disorder. Resident #3's service plan included assistance with meal preparation, laundry, housekeeping, medication management, and behavior monitoring. Resident #3's assessment identified a history of depression, anxiety, verbal aggression, and angry outbursts.

Resident #2 reported to facility staff that Resident #3 made sexual comments while holding a knife to Resident #2's throat. Staff reported and investigated the allegation but found no evidence to support the incident occurred. Resident #2 later reported to facility staff they did not feel threatened by Resident #3.

Investigative interviews and facility documentation included no evidence of incidents or reports of altercations that occurred between Resident #2 and Resident #3.

Resident #2 was interviewed and could not recall any incident of sexual comments or sexual assault that occurred involving Resident #3.

Attempts to contact Resident #3 were unsuccessful.

During an interview, facility management staff indicated they were not aware of the incident involving the visitor and Resident #3. Facility management staff stated they reported Resident #2's allegation of sexual assault and initiated an investigation. Video footage was reviewed but there was no evidence of interaction between the residents.

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: Resident #1- No contact information available.
Resident #2- Yes
Resident #3-Attempts to contact were unsuccessful.
Family interviewed: Attempts to contact were unsuccessful.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
The facility reported and investigated Resident #2's report of sexual assault.

Action taken by the Minnesota Department of Health:
No action taken

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
	36852	A. BUILDING: _____ B. WING _____	C 08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOMES LLC	1509 SUGARLOAF TRAIL 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 On August 22, 2023, the Minnesota Department of Health initiated an investigation of complaints #HL368523403M/HL368525467C, #HL368524244M/HL368527180C, #HL368527885M/HL368524776C, #HL368527886M/HL368524777C. No correction orders are issued.	0 000		