Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL368527885M
Compliance #: HL368524776C

Date Concluded: November 16, 2023

Name, Address, and County of Licensee Investigated:
Berkeley Heights Home 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 a resident when the facility did not report, investigate, or follow-up on sexual assault allegations reported by the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Staff followed facility policies and procedures, reported, and investigated allegations of sexual assault reported by the resident. There was no evidence to support sexual assault occurred.

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 the resident's medical records, personnel records, and facility policies and procedures. At the time of the onsite visit, the investigator observed staff interactions with residents and medication and treatment administration.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder and bipolar disorder. The resident's service plan included assistance with medication management, meal preparation, hourly safety checks, and daily behavior monitoring. The assessment indicated the resident had a history of sexual abuse, difficulty sleeping, hallucinations, physical aggression, verbal aggression, cursing, and being resistive to care.

The resident's medical record identified the resident had scheduled lab blood draws which required lab personnel to visit the facility to obtain the blood sample. Facility staff were scheduled to be present at the time of the lab draws to assist lab personnel if needed. During one of the scheduled lab draws, the resident alleged the male lab personnel touched her inappropriately. Facility staff were present at the time and denied the incident occurred. Facility staff witnessed the male lab technician attempt to draw blood from the resident's arm and the resident became upset because she wanted the needle to "do it herself." When the lab technician refused to provide the resident the needle, the resident accused the technician of touching her inappropriately. Facility staff had the lab technician leave the facility and lab draws were later scheduled to be completed at the clinic.

Law enforcement logs indicated police were sent to the facility multiple times to follow-up on reports of sexual assault of the resident. The resident and staff were interviewed but no further action was taken, and law enforcement indicated there was no evidence to suggest that sexual assault occurred.

Another incident involved the resident calling 911 for assistance. Two case workers responded and informed facility staff they were contacted by the resident. The resident had a private conversation with the two public case workers. The case workers had no further questions for staff and left the facility.

During an interview, nursing staff indicated the resident had a history of paranoid behaviors with hallucinations that would cause her to become accusatory. Interventions were in place for staff to redirect and provide reassurance through one-to-one conversation. Facility management and nursing staff were aware of the multiple allegations of sexual assault and cooperated with law enforcement to investigate the incidents.

The resident did not respond to request for interview.

The resident's family declined requests for interview.

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: No, did not respond to requests for interview
Family/Responsible Party interviewed: No, family declined to be interviewed.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility reported and investigated allegations of sexual assault and implemented interventions to prevent further occurrence.

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		