Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL373623145M
Compliance #: HL373622051C

Date Concluded: August 12, 2026

Name, Address, and County of Licensee Investigated:
Brooklyn Park Assisted Living
7731 Humboldt Avenue North
Brooklyn Park, MN 55444
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Inconclusive

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 alleged perpetrator (AP) neglected the resident when the resident complained of difficulty breathing and the resident's oxygen saturation level was critically low at 67%. The resident was hospitalized with a pulmonary embolism (a blood clot in the lung).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Verbal accounts of the resident's oxygen levels at the time of the incident differed. All the resident's documented oxygen levels were 90% or above. However, the resident's oxygen levels at the time in question were not documented. The resident had a history of anxiety and the overlapping symptomology of pulmonary embolism. The resident was hospitalized with a pulmonary embolism, required surgery to remove the clots and returned to baseline.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included review of the resident record, hospital records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident cares and staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included traumatic brain injury, quadriplegia, and anxiety. The resident's services included assistance with activities of daily living, meals, housekeeping, and medication management. The resident's assessment indicated he required full assistance with most activities.

The resident's progress notes indicated he complained of anxiety one evening and requested his as needed (PRN) medication. The resident then complained of difficulty breathing. His vital signs were within normal limits, with an oxygen level of 90% on room air. After taking his medication, he reported feeling better. The following day, the resident complained of shortness of breath. Staff called 911 and emergency services personnel (EMS) transported the resident to the hospital. At the hospital, the resident was diagnosed with a pulmonary embolism and placed on an anticoagulant (blood thinning) medication. The resident returned to the facility four days later. The resident's oxygen level upon return was 97% on room air and he did not complain of further respiratory distress.

The resident's hospital records indicated he was admitted with a diagnosis of pulmonary embolism. The resident's oxygen level at the time of admission was 92 to 93% on room air. He underwent a thrombectomy (removal of the blood clot I his lung) and was placed on anticoagulant medication. The cause of the embolism was unknown, but it was perhaps it might be related to the resident's immobility. The resident returned to the facility four days later on anticoagulant medication. The resident did not require the use of supplemental oxygen upon discharge.

When interviewed, an administrator said the day before the resident entered the hospital, he complained of anxiety. A staff member took the resident's vital signs and they were normal. The next day the resident continued to feel symptoms of anxiety and staff called 911. At the time, the resident was lucid and conversational. EMS said it looked like the resident was having "a little anxiety." The administrator recalled EMS took vitals signs, oxygen was in the 90s but could not recall the number. The resident's oxygen was not regularly checked before his hospitalization because he had no order for it and had never reported shortness of breath. His medical condition caused him a lot of anxiety, because of the loss of function. Prior to his admission, it was reported the resident had a history of anxiety. When the resident first complained of symptoms, they were attributed to anxiety. As the resident continued to complain of symptoms, he was sent to the hospital for further assessment. Since returning from the hospital, the resident's condition had remained stable.

The resident's family member said she was disappointed the facility did not notify her of the resident's hospitalization, as she found out after the fact. The family member was very concerned about the care the resident received, as she believed the resident's oxygen level before he was hospitalized was between 72% to 76%. Since the hospitalization, however, things had improved and the resident felt more comfortable living there.

When interviewed, the resident said he had an oxygen level of 68% one night and the AP still put him to bed. The resident said he could not breathe and thought he was having a panic attack. The next day the resident said he felt the same way so he wanted to go to the hospital. He was diagnosed with a pulmonary embolism, underwent surgery, and then returned to the facility. The resident said he was doing "okay" since returning to the facility.

When interviewed, the AP said one evening the resident complained of feeling anxious. The AP completed a set of vital signs, which were within normal limits, with an oxygen level reading of around 92%. The AP administered anxiety medication to the resident. The next day, the resident continued to complain of anxiety. His vital signs were within normal limits, and his oxygen level was still above 90%. The resident said he wanted to go to the hospital, so staff called 911. EMS checked the resident's vital signs, which were close to what the AP had taken. The AP recalled the resident's oxygen level was in the high 90s, and his pulse was in the 60s. The AP said the resident's oxygen level had never been below 90% since moving to the facility, so the AP was unsure of where the resident got a number for an oxygen level in the 60's. The AP wondered if the resident thought his pulse reading was the oxygen level and got the numbers confused. The AP said if anyone had an oxygen level in the 80s or below, she would immediately send them to the hospital.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility attended to the resident as he complained of symptoms and sent him to the hospital for further assessment.

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
	37362	A. BUILDING: _____ B. WING _____	C 07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKLYN PARK ASSISTED LIVING	7711 HUMBOLDT AVENUE NORTH 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 July 8, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL373622051C/#HL373623145M. 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 Facilities. 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 evaluators' 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 SUBDIVISION 1-3.	