DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL369258384M
**Compliance #:** HL369255499C

**Date Concluded:** May 16, 2024

**Name, Address, and County of Licensee Investigated:**
Miles Vents Inc.
5336 Sailor Lane
Brooklyn Center, MN 55429
Hennepin County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** James P. Larson, 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 the resident when staff failed to provide supervision after the resident requested a razor and was able to harm herself.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was not substantiated. The resident's care plan was followed at the time of the incident. Although staff provided the resident with a razor, at the time of the incident, the resident was able to utilize a razor independently without staff's supervision.

The investigator conducted interviews with facility administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's family. The investigation included review of the resident's record, facility incident reports, personnel files, and facility policies and procedures. At the time of the onsite visit, the investigator toured the facility and observed staff to resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included post-traumatic stress disorder (PTSD) and attention deficit hyperactivity disorder (ADHD). The resident's service plan included assistance with medication management, housekeeping, laundry, and meals. The resident's admission assessment included a history of violent behavior towards staff and previous suicide attempts.

On the day the incident occurred, the resident asked staff for a razor to shave her legs. Staff provided a razor to the resident and the resident went into the bathroom unsupervised. A short time later, the resident returned the razor and reported to staff that she cut herself and needed an ambulance. Staff observed the resident had inflicted small cuts to her left wrist. Staff immediately contacted the nurse, and the resident was transported to a local hospital for observation and treatment. Hospital documentation described the wounds as superficial, and the resident returned to the facility later that same day.

During an interview, a facility staff member stated that prior to the incident, the resident had been permitted to shave unattended. The staff member stated that when the resident reported that she cut herself, the wound was not bleeding, and she thought the injury looked more like a bruise. Staff stated that they followed facility procedures and notified the nurse and contacted emergency medical services.

During an interview, a nurse at the facility stated that although the resident had a history of suicidal behavior, this was the first and only incident of this type of behavior that occurred at the facility. Upon the resident's return to the facility, additional interventions were implemented to ensure the resident's safety.

During an interview with the resident's family, they indicated that they had no concerns with the care provided by the facility.

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**: Yes.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: Yes.

**Action taken by facility:**
Following the incident, additional safety interventions were implemented, and facility staff received additional training.

**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 |
|---|---|---|---|
| | 36925 | A. BUILDING: _____ B. WING _____ | C 04/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MILES VENTS INC | 5336 SAILOR LANE BROOKLYN CENTER, MN 55429 |

| (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<br><br>On April 1, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL369255499C/#HL369258384M. No correction orders are issued. | 0 000 | | |