Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL346026385M
Compliance #: HL346022056C

Date Concluded: February 1, 2024

Name, Address, and County of Licensee Investigated:

Dis-Generation Group Home
6825 46th Ave. North
Crystal, MN 55428
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, 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):
Facility staff neglected a resident when the resident used a facility kitchen knife to cut his neck, resulting in hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Upon admission to the facility, nursing staff identified and implemented interventions to address the known vulnerabilities of the resident. Although the incident occurred, the resident's plan of care was followed at the time of the incident. The resident was transported to the hospital for evaluation and treatment. Upon his return to the facility, additional safety and supervision interventions were implemented to ensure the resident's safety.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical record, hospital records, personnel files, police reports, and facility policies and procedures. At

the time of the onsite visit, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included Schizophrenia, anxiety, and a history of self-harm. The resident's care plan included assistance with housekeeping, medication management, and behavioral support. The resident's assessment indicated the resident had a history of cutting himself and all sharp objects were to be kept out of the resident's reach.

Upon the resident's admission to the facility, staff were informed to keep all sharp objects away from the resident. The facility had one knife available for staff use and staff were directed to hide the knife in a secure location. Each shift hid the knife in a different location in the kitchen and informed the oncoming shift of the knife's location during the change of shift report.

An incident summary indicated the resident retrieved a knife from a kitchen cupboard, went to the bathroom, and cut his neck. Staff immediately contacted 911 and the resident was taken to the hospital for evaluation and treatment.

Hospital records indicated the resident told hospital staff he was making a music video and cut himself on accident. A three-centimeter laceration on the resident's neck was sutured and the resident returned to the facility.

Upon the resident's return to the facility, the resident was assessed, and additional safety and supervision interventions were implemented.

During an interview, a facility staff member stated the day the incident occurred, the resident ate his meal in the kitchen then went to his room. The staff member checked on another resident and during that time, the resident found the knife in the kitchen and brought it into the bathroom. When the resident came out from the bathroom, the staff member saw blood on the resident's neck and called 911. The staff member denied leaving the knife unattended or within the resident's reach and stated they did not know how the resident found the knife because the knife was hidden.

During an interview, the facility nurse recalled the resident admitted to the facility one week prior to the incident. The nurse stated staff completed scheduled safety checks and made additional observations of the resident due to his frequent smoking habits. The nurse stated at the time of the incident, the knife was hidden in the kitchen, per protocol, and she did not know how the resident found the knife. The nurse stated that after the incident, new interventions were implemented; the resident was placed on 1:1 staffing, all sharp objects were locked, and the facility implemented the use of plastic utensils.

During investigative interviews, the resident's case managers stated the facility was overall willing and supportive to the resident's needs, however, the resident was later discharged to a facility better equipped to meet his needs.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

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.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Vulnerable Adult interviewed: Not available for interview
Family/Responsible Party interviewed: No. Attempts made were unsuccessful.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility had interventions in place prior to the incident. When the incident occurred, the resident was sent to the hospital for evaluation. Following the incident, additional interventions were implemented.

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
	34602	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIS-GENERATION GROUP INC	6825 46TH AVENUE NORTH BROOKLYN CENTER, MN 55428

(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 December 18, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL346022056C/#HL346026385M. No correction orders are issued.	0 000	Assisted Living Provider 144G. 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.	