

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL361075143M
Compliance #: HL361077002C

Date Concluded: December 26, 2024

Name, Address, and County of Licensee

Investigated:

Bella Vie Living LLC
7001 Emerson Avenue North
Brooklyn Center, Minnesota 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, 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 alleged perpetrator (AP) neglected the resident when the AP left the resident alone to make dinner during an episode of self-harm. While alone, the resident attempted to commit suicide.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Although the AP left the resident alone to make food for other residents, the error was an isolated incident. The resident sustained cuts to her arm, went to the hospital, received stitches and psychiatric care, and returned to their baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted case managers, family, and the county's mobile crisis response team. The investigation included review of the resident record, hospital record, ambulance service's incident report, facility incident reports, personnel files,

staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed resident safety and staff supervision of residents.

The resident resided in an assisted living facility. The resident's diagnoses included several mental health diagnoses. The resident's service plan included assistance with supervision and monitoring the resident to help prevent and re-direct self-abusive behaviors and suicidal thoughts.

The resident's assessment indicated the resident expressed suicidal ideation on a daily basis, and staff occasionally found sharp objects she hid in her room. The assessment identified the resident as being very open with staff when having suicidal urges. Staff were to continue to follow the behavior plan and call the mobile crisis response team when the urges were severe.

An incident report indicated the AP found the resident on the floor of the bathroom in a pool of blood and a blade beside her. The resident stated she went to the store earlier and purchased the blade in hopes of ending her life. The AP provided first aid, including applying pressure to stop the bleeding. Emergency medical services (EMS) arrived and transferred the resident to the hospital.

The resident's record included a progress note written by the AP. The progress note indicated the resident had been hanging out at the staff desk when the AP arrived for her shift. About one hour later, the resident requested bandages for a cut she self-inflicted with a pencil case. The AP performed first aid and removed the pencil case from the resident's possession. The AP called the county's mobile crisis response team and informed the resident they would arrive shortly. As the AP made dinner, the resident went to use the bathroom. After dinner, the AP became concerned the resident had taken too long in the bathroom, so she knocked and asked if she was okay. The resident responded no, so the AP asked to enter the bathroom. After the resident unlocked the door, the AP walked in and saw a pool of blood. The resident showed the AP the blade she used to cut herself. The AP removed it from the resident's possession and started providing first aid. The AP tried calling 911, but the call dropped. When the mobile crisis response team member arrived, they called 911 while the AP continued to provide first aid. EMS arrived, assisted the resident, and transported her to the hospital.

The ambulatory service's incident report indicated the resident locked herself in the bathroom and made several self-inflicted cuts to her arm. The resident reported she intended to end her life. The resident's injuries included two superficial cuts to the wrist, and one deep cut to the forearm which exposed fat tissue. EMS assessed the resident, performed wound care, and transported her to the hospital.

The resident's hospital record indicated the resident received 10 stitches in the emergency room, then transferred to a psychiatric unit within the hospital for observation for four days before discharging to a new living facility. During the resident's hospitalization, the resident continued to endorse thoughts of self-harm.

During an interview, a nurse stated the facility could not provide one-to-one staffing for the resident, but staff had removed her personal belongings from her room to try keeping her safe. The resident ordered items in the mail for self-harming purposes, so the facility started checking the resident's mail. Additionally, the resident would leave the facility and return with items like razor blades. Despite everything the facility implemented to keep her safe, the resident continued to make threatening comments about hurting herself. The facility also started utilizing the county's mobile crisis response team.

During an interview, the AP stated she talked with the resident at the beginning of her shift. The resident mentioned looking forward to moving to her new living facility. The AP went to complete services for other residents and returned to the desk to chart. The resident then showed the AP a superficial cut and told the AP she used a pencil box cover to cut herself. The AP completed first aid, and since the resident admitted to continued thoughts of self-harm, called the county's mobile crisis response team. The AP and the resident went into the resident's room to look for anything else she could possibly use to hurt herself but found nothing. Before the mobile response crisis team member arrived, the AP began to make dinner for the residents. While making dinner, the AP observed the resident go into the bathroom through the door facing the kitchen. At that point, nothing seemed out of the ordinary. After some time, she noticed she had not seen the resident come out of the bathroom. The AP knocked on the bathroom door to check on the resident and asked if she was okay. The resident responded no. The resident unlocked the door and allowed the AP in. The AP saw blood and called 911. During the call, she lost connection with 911. When the mobile crisis response team member arrived, she asked him to call 911. The AP applied pressure to the resident's arm until EMS took over.

During an interview, the resident stated she did not remember most of the incident. The resident did recall sitting in the bathroom and seeing the blood. The resident thought the AP was sad for her and panicked a little bit. The AP grabbed paper towels and stayed with her until the police and EMS arrived. In general, she thought everyone did as much as they could for her.

During an interview, a family member stated overall, the facility did a good job of handling the resident's mental health needs. The resident had an increase in self-harm attempts and the lengths she was willing to go to harm herself the last few months leading up to this incident. Since the resident moved directly from the hospital to a new living facility with one-to-one staffing, she has remained stable.

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:

The facility called the county mobile crisis response team when the resident was experiencing suicidal ideations. The facility also maintained contact with the resident's care team and helped her find more appropriate housing with increased supervision.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BELLA VIE LIVING LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7001 EMERSON AVENUE NORTH BROOKLYN CENTER, MN 55430
---	---

(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	<p>Initial Comments</p> <p>On November 5, 2024, the Minnesota Department of Health initiated an investigation of complaint HL361077002C/HL361075143M. No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____