Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL369259162M
Compliance #: HL369257561C

Date Concluded: March 10, 2025

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: Peggy Boeck, RN, Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota 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 they failed to check the resident's room after she did not return from an outing. The facility waited five days to file a missing person's report or notify the state agency. Three weeks later the facility opened the residents room door and found her deceased.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility was aware the resident was using illicit drugs and used the bedroom window to come in and go out of the facility, however, the facility failed to train staff to recognize potential substance use, failed to implement new interventions to mitigate the risk of the substance use, and failed to develop interventions related to the resident using her window as an entrance/exit. When the resident appeared to be missing, facility staff did not open the resident's room to check if the resident had returned via the window, for several weeks. A staff and a resident recalled the facility was particularly cold for

several weeks before anyone entered the resident's room to check for an open window. The facility had a supply of Narcan for use in the event of an overdose. The resident was found deceased in the facility in her room approximately three weeks after the resident went missing.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the medical examiner. The investigation included review of the resident record, death record, medical examiner record, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed the facility, resident's room, and staff/resident interactions.

The resident lived in an assisted living facility due to diagnoses that included schizoaffective disorder, anxiety, and substance use disorder. The resident's service plan included assistance with meals, medication administration, daily housekeeping and laundry three times per week.

The resident's abuse prevention plan indicated she was at risk for abuse, but did not identify the resident's history of substance use or specific staff interventions for suspected drug use.

The resident's assessment indicated the resident used a prescribed medication to help with sobriety. Progress notes indicated the resident had stopped taking the medication a month before the resident's death.

The resident's documentation from an outside provider dated two months before her death included drug screens which were positive for illicit drugs.

A progress note indicated one Friday the resident went out and did not return as expected.

During an interview, a staff stated she observed the resident leave with her boyfriend that Friday and the resident did not return by the time the staff left the facility at 7:00 p.m.

Progress notes for the next three days indicated the resident had not returned and no one had heard from the resident. There was no documentation anyone looked in the resident's room.

A progress note indicated the activities director looked in the resident's room on the third day, did not see the resident, so locked the room. There was no documentation of whether the resident's window was open.

A police report indicated the facility filed a missing person report five days after the resident had left the house and not returned.

A progress note indicated six days after the resident left the house, the facility called hospitals looking for the resident.

A report indicated staff called 911 twenty days after the resident left the house, with a report of an unresponsive resident. The report indicated staff found the resident deceased in her room when they unlocked the door to check for an open window. The report indicated the resident had been deceased for a significant amount of time. Officers saw drug paraphernalia out in the open.

A police report indicated the resident's boyfriend reported during a police interview that he and the resident had bought drugs on Friday [the night the facility indicated the resident was missing]. They (the boyfriend and resident) crawled in through the resident's window and used the drugs in her room. The boyfriend stated they both passed out and when he woke up, he found the resident deceased. The boyfriend stated he tried to revive the resident, panicked, and exited out the window. The boyfriend told police he worried he would be in trouble for not calling 911.

Police investigation video of the resident's boyfriend's phone activity showed the resident texted her boyfriend on the day she left the house. The video showed the boyfriend texted the resident four days later looking for her. There was no text communication between them in the days between. The video showed the boyfriend reported the resident's death to others seven days before the resident's body was found in the facility.

During an interview, a housemate stated she knew and reported months earlier to an administrator/nurse the resident used her bedroom window to enter and exit with her boyfriend. The housemate stated there was cold air blowing from the resident's room for weeks. The housemate stated she told staff, but no one went into the resident's locked room to check. The housemate stated on the day they found the resident deceased in her room, she finally convinced a staff to unlock the resident's room to check why there was a cold draft, and that was when they found the resident deceased.

During an interview, an administrator/nurse stated she knew the resident was coming and going through her bedroom window but made no changes to the resident's abuse prevention plan or service agreement. The administrator/nurse stated she could have added another outside surveillance camera, and it would have been a good idea to train staff how to look for signs and symptoms of drug use.

During an interview a nurse/supervisor stated she and the administrator/nurse regularly communicated about the residents at all their facilities, but the nurse/supervisor had not heard the resident had been using her window to come and go. The nurse stated her responsibility included review of medical reports. The nurse stated when the outside provider medical report showed the resident's drug screen was positive for illicit drugs, she talked to the resident and hoped the resident would stop using drugs. The nurse stated the resident's abuse prevention plan should have been updated when they received information about the resident's drug use.

During investigative interviews, multiple staff members stated they did not receive training on how to look for suspected drug use. The staff also reported they could not remember if anyone went into the resident's room between the first day she was missing and when they found her.

During an interview, the activity director stated he opened the resident's door three days after the resident failed to return and saw nothing unusual. The activity director stated the resident's window was not open when he checked, and he locked the door when leaving. The activity director stated the key to the resident's room was available to staff.

The Medical Examiner's report was not complete by the conclusion of the investigation.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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, deceased.
Family/Responsible Party interviewed: Unable to reach family, spoke with resident's case manager.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility planned to educate staff on signs and symptoms of drug use.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html
If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Brooklyn Center City Attorney
Brooklyn Center Police Department
Minnesota Board of Executives for Long Term Services and Supports

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 02/14/2025

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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL369257561C/#HL369259162M On February 14, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 2 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL369257561C/#HL369259162M, tag identification 0620, 2310, and 2360.	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.	
0 620 SS=F	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.	0 620		

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0 620	Continued From page 2 (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to immediately report suspected maltreatment of one of one residents (R1) to the Minnesota Adult Abuse Reporting Center (MAARC), when R1 failed to return from an outing. The licensee failed to follow their policy for a missing resident when they failed to promptly organize a search, notify law enforcement, and/ or file a MAARC report. The facility also failed to file a report with MAARC when staff discovered R1 deceased in her bedroom. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 620	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	

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0 620	Continued From page 3 of the residents). Findings include: R1 moved into the assisted living on May 9, 2022, due to diagnoses that included schizoaffective disorder, generalized anxiety, and substance use disorder. R1's service plan (undated) indicated R1 received assistance with meals, and medication administration. The service plan indicated R1 was independent with all activities of daily living. R1's individual abuse prevention plan (IAPP) dated January 10, 2024, indicated R1 was at risk for sexual abuse due to an "inability to be assertive", physical abuse due to an "inability to deal with verbally/physically aggressive persons", and financial exploitation due to her "generous nature". R1's IAPP indicated no specific measures to minimize risk of abuse but directed staff to "report any suspected abuse to RN immediately, RN to investigate and report to MAARC within 24 hours." R1's nursing assessment dated November 20, 2024, indicated staff washed R1's laundry three times per week and completed daily housework assistance. The assessment indicated R1 had poor decision making, and "wants to please others no matter the cost." The assessment indicated R1's evacuation plan in case of emergency included "leave via window or door." During an interview on February 14, 2025, at 10:00 a.m. a housemate (R2) stated she told the nurse (registered nurse, assisted living director RN/ALD-B) in December that R1 was going out the window and coming back in with her boyfriend.	0 620	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.	

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0 620	Continued From page 4 During an interview on February 14, 2025, at 3:12 p.m. RN/ALD-B confirmed their Maltreatment policy indicated the facility should file a report with Minnesota Adult Abuse Reporting Center within 24 hours of suspected incident of maltreatment. RN-B stated she had no information that anyone maltreated R1 and waited to file the report incase R1 returned home. During an interview on February 19, 2025, at 1:20 p.m. registered nurse/clinical nurse supervisor (RN/CNS)-E stated she had concerns about R1's safety as R1 would meet people on the street and bring them into the facility. RN/CNS-E stated the facility policy included calling 911 and filing a MAARC report, but the facility waited a week, because R1 had been away from the home before and, "hoped she would return." RN/CNS-E stated she reviewed all reports that came from R1's psychiatric provider which included drug screens. RN/CNS-E stated it was up to the provider to talk to R1 about illicit drugs that showed up in her drug screen. The facility Missing Resident policy dated August 1, 2021, indicated the licensee would immediately investigate any missing resident using an organized approach in order to ensure that if a resident is found to be missing, the appropriate authorities were notified. The Vulnerable Adult policy dated August 1, 2021, indicated the facility was required to individually assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse to that resident. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 620		

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02310 SS=J	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide appropriate care and services for one of one residents (R1) reviewed for maltreatment. R1 had a history of substance use disorder (amphetamines and opioids), documented use of amphetamines, opioids, fentanyl, and THC in recent drug screens. The licensee failed to update R1's service plan and individual abuse prevention plan to include interventions related to drug use and failed to train staff on recognizing drug use. In addition, the licensee failed to communicate with staff that R1 had been using her bedroom window for exit/entrance for herself and others and failed to create and ensure implementation of interventions specific to R1's use of her window as an exit/entrance. Staff found R1 deceased in her bedroom 20 days after staff first identified the resident was missing and had no idea when she entered the bedroom. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	02310	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.	

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02310	Continued From page 6 Findings include: R1 moved into the assisted living on May 9, 2022, due to diagnoses that included schizoaffective disorder, generalized anxiety, and substance use disorder. R1's service plan (undated) indicated R1 received assistance with meals, and medication administration. The service plan indicated R1 was independent with all activities of daily living. The service plan did not identify R1's history of substance use or include staff interventions for use or suspected use of substances. R1's mental health care plan dated May 9, 2022, included check boxes listing general behaviors and check boxes listing general interventions. The plan included the following interventions for anxious behavior: Identify what the resident is to do, speak respectfully in a calm voice, and do not argue or reinforce the behavior. The plan did not include R1's history of substance use, or specific interventions for staff to use with R1 related to substance use. R1's individual abuse prevention plan (IAPP) dated January 10, 2024, indicated R1 was at risk for sexual abuse due to an "inability to be assertive", physical abuse due to an "inability to deal with verbally/physically aggressive persons", and financial exploitation due to her "generous nature". R1's IAPP indicated measures to minimize risk of abuse included "staff to report any suspected abuse to RN immediately, RN to investigate and report to MAARC within 24 hours." R1's IAPP did not include R1's history of substance use, history of use of her window for exit/entrance, or specific staff interventions for staff to use with R1.	02310	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.	

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02310	Continued From page 7 R1's nursing assessment dated November 20, 2024, indicated R1 had a history of substance use. The assessment indicated R1 had poor decision-making ability and wanted to please others, "no matter the cost". R1's medical record (received by the facility on December 12, 2024), indicated R1 received mental health services from an outside provider. The medical record indicated R1 had long standing difficulty with opiate addiction of approximately ten years. The report indicated on September 25, 2024, R1 told her provider she was using a $50 bag of methamphetamine once a month, often mixed with unknown substances. The record indicated R1 told her provider that she tapered herself off Suboxone (a medication prescribed for reducing opioid misuse) prior to a December 3, 2024, telephone visit. The record indicated monthly drug screens used to verify presence of Suboxone also showed positive results for illicit drugs on the following dates: January 3, 2024, positive for THC (the main psychoactive ingredient in cannabis). February 23, 2024, positive for amphetamine, methamphetamine, cocaine, fentanyl, and THC. June 11, 2024, positive for methamphetamine, cocaine, oxycodone, and THC. July 11, 2024, positive for methamphetamine, fentanyl, and THC. September 25, 2024, completed, but results not documented. R1's progress note dated December 3, 2024, indicated R1 participated in a telephone psychiatry appointment, during which she requested to discontinue her Suboxone, and the provider agreed. R1's progress note dated January 17, 2025,	02310		

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02310	Continued From page 8 indicated staff reported to registered nurse, clinical nurse supervisor (RN/CNS)-E that R1 went out and had not returned as expected. The note indicated, "staff will wait for resident return." R1's progress note dated January 18, 2025, indicated staff reported there was no sign of R1. R1's progress note dated January 19, 2025, indicated R1 had not returned to the house. The note indicated they asked a housemate (R2), who had not heard from R1. R1's progress note dated January 20, 2025, indicated activities director (AD)-L "checked [R1's] room and there was no one in it, then locked the door". R1's progress note dated January 21, 2025, indicated the facility was unable to reach R1's family member. The note indicated the facility received no word from R1. R1's progress note dated January 22, 2025, indicated staff reported R1 had not returned. R1's progress note dated January 23, 2025, 6 days after R1 was last seen, indicated RN/ALD-B called police to report R1 had been missing since January 17, 2025. The note indicated calls were made to a motel where R1 had gone in the past. R1's progress note dated January 24, 2025, indicated calls were placed to hospitals (Hennepin County Medical Center, North Memorial, Unity, and Regions) but R1 was not at any of the hospitals. The note indicated a report was sent to the state agency that day and R1's case manager (CM-C) was notified.	02310		

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	36925	A. BUILDING: _____ B. WING _____	C 02/14/2025

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02310	Continued From page 9 A police report dated February 6, 2025, indicated at 4:13 p.m. officers were dispatched to the facility and upon responding located R1 deceased on her bed. The report indicated officers observed multiple items indicative of drug use. The report indicated the window was open (screen off and set inside the room) and it was very cold in the room. The report indicated a resident (R2) shared with officers a Facebook post by R1's boyfriend that indicated "rest in peace." The post was time stamped 18 hours prior. The report indicated the boyfriend was located and interviewed. The report indicated the boyfriend stated he and R1 smoked drugs in her room, passed out, and R1 died. The boyfriend told police he tried to revive the resident, panicked, and left out the window without telling anyone. The boyfriend identified the date of the incident as January 17, 2025, and indicated R1's housemate had reached out to him by text, looking for R1 the next day, so he was sure of the date. The report indicated police reviewed and took video of the boyfriend's phone. The videos were reviewed by the MDH investigator. The video showed the last text from R1 was on January 17, 2025, at 5:30 p.m. and the boyfriend sent a one word text to R1 on January 21, 2025, at 11:45 a.m. "Baby". The boyfriends next texted R1 on January 22, 2025, at 2:04 p.m. indicating he worried about R1 and wondered why she did not text or call him back. The boyfriend's texts also included one dated January 30, 2025, at 4:48 p.m. to a contact regarding R1 that stated "She died." and a text to a family member dated January 31, 2025, at 5:19 p.m. that stated "They found her, [R1] was in her room, dead on her bed".	02310		

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02310	Continued From page 10 On February 14, 2025, the Minnesota Department of Health investigator observed and photographed the inside and outside of the facility. R1's corner, main floor room had three windows, one facing west and two facing north. The investigator observed and photographed the north facing window situated directly over an egress cover, the top of which was approximately two feet off the ground. The outside frame of R1's window had no screen and had two areas on the lower frame with paint scraped off. The investigator observed there were no surveillance cameras pointing to the area. During an interview on February 14, 2025, at 10:00 a.m. a resident (R2) stated she reported to facility administration that R1 had used her window to leave her room. R2 stated R1 would bring men or her boyfriend into her room through the window. R2 stated that on the evening they found R1's body, she had asked a staff to go into R1's room to see if a window was open because there was a draft blowing cold air into R2's room across the hall. R2 stated she complained to staff about the cold in the house for several weeks. During an interview on February 14, 2025, at 3:12 p.m. RN/ALD-B stated staff received no training on signs and symptoms of drug use and thought maybe that would be a good idea in the future. RN/ALD-B stated she was aware R1 had drug screens positive for illicit drugs. RN/ALD-B stated she was told by one of R1's peers (R2) in December 2024 that R1 was letting men in through the window, to avoid the facility surveillance cameras. RN/ALD-B stated they did not institute a plan to check R1's room but instructed staff to inform a nurse if R1 returned. RN/ALD-B stated she did not document this information, did not make changes to R1's	02310		

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02310	Continued From page 11 service plan interventions or IAPP, or put in additional surveillance cameras. During an interview on February 14, 2025, at 3:15 p.m. case manager (CM)-C stated the facility had discussed asking R1 to leave the facility but had not done anything formally. CM-C stated R1 was very scared of being kicked out. CM-C stated she had concerns about the facility's lack of wellness checks of R1. During an interview on February 19, 2025, at 10:37 a.m. house manager (HM)-D stated he had no idea R1 was using drugs, but did believe R1 was drinking alcohol. HM-D stated if the nurse knew R1 went in and out of the window, the nurse should have reported it to him. During an interview on February 19, 2025, at 1:20 p.m. RN/CNS-E stated she reviewed R1's medical records from her mental health provider. RN/CNS-E stated it was up to the provider to let R1 know what was in the drug screen. RN/CNS-E stated she thought it would be best if the provider offered R1 outpatient drug treatment, but the facility hoped R1 would just not use drugs. RN/CNS-E stated she and RN/ALD-B shared nursing duties but thought RN/ALD-B updated R1's IAPP and service plan. RN/CNS-E stated staff should report any unusual resident behavior but could not identify training provided for staff regarding signs/symptoms of drug use. During an interview on February 19, 2025, at 3:06 p.m. unlicensed personnel (ULP)-F stated he did not know what R1 did in her room, or if she was using drugs in there, as staff never entered R1's room as it was R1's preference. ULP-F stated he did not receive training on signs/symptoms of drug use.	02310		

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02310	Continued From page 12 During an interview on February 19, 2025, at 3:36 p.m. ULP-G stated she observed R1 sneak out the front door a couple of times during the middle of the night, when R1 thought ULP-G was asleep. ULP-G stated she recalled the house was cold when she worked the week before R1 was found. ULP-G stated the thermostat was locked and it was 50-60 degrees in the house, so they walked around with blankets on. ULP-G stated she received no training on signs/symptoms of drug use. During an interview on February 24, 2025, at 10:55 a.m. AD-L stated he viewed R1's room on January 17, 2025, the first day R1 was reported to be missing and R1 was not in the room. AD-L stated his manager told him to look in the room again on January 20, 2025, and the room looked the same, the bed was made, and R1 was not in there. AD-L stated R1 had never been out of the facility for more than a day. AD-L stated he received training on Narcan and its location in the facility upon hire. The Clinical Records policy dated August 1, 2021, indicated the resident record contained documentation of incidents and/or significant changes in the resident's status and actions taken in response to the needs of the resident. The Service Plan policy dated August 1, 2021, indicated a service plan was developed for the resident based on the assessed needs of the resident. The policy indicated the service plan must be revised based on resident review or reassessment. The Missing Resident policy dated August 1, 2021, indicated the facility would immediately	02310		

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02310	Continued From page 13 investigate any missing resident using an organized approach. The policy indicated the staff member informed of a missing resident would promptly organize a local search of the building and immediate vicinity. The policy indicated the staff would then contact the director and/or clinical nurse supervisor. The policy directed the director, clinical nurse supervisor to notify law enforcement, the resident's representative, and case manager. The policy indicated a MAARC report would be completed. TIME PERIOD FOR CORRECTION: Two (2) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		