Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL264431020M
Compliance #: HL264438222C

Date Concluded: June 20, 2024

Name, Address, and County of Licensee Investigated:
Miles Vents Incorporated
5701 Shingle Creek Parkway, #115
Brooklyn Center, MN 55430
Hennepin County

Facility Type: Home Care Provider

Evaluator's Name: Michele Larson, BSN, 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 and the alleged perpetrator (AP) neglected the client when they failed to perform face-to-face nursing visits.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The AP completed in-person assessments as required. The client's family member, a registered nurse (RN), was employed by the facility to provide cares and services to the client on a daily basis, along with other facility RN's. During an interview, the client's family member stated the AP regularly completed in-person nursing visits with the client.

The investigator conducted interviews with the AP and the client's family member. The investigation included review of the resident's record and state surveyor's onsite visit notes, forms, and documentation.

The client received comprehensive home care services in their home. The client's diagnoses included legal blindness, convulsions, congenital brain, and seizure disorders. The client's care plan indicated the client received assistance with stomach (G-tube) feedings, toileting, passive range-of-motion (PROM), supplemental oxygen at night, as needed (PRN) postural drainage and chest pummeling (percussion), to drain secretions and loosen mucus. The client was unable to report abuse or neglect and was dependent on staff for transfers and mobility. The client used a wheelchair for mobility.

Review of the client's record indicated the client received daily nursing services from facility staff. Nursing staff documented detailed flow sheets on the services they provided to the client, along with daily progress notes and concerns. The AP conducted comprehensive in-person assessments on the client timely.

During an interview, the client's family member stated the AP performed regular nursing visits and assessments for the client. The client's family member stated the AP's documentation was detailed, stating the AP's documentation was better than other agencies documentation. The family member stated she felt the AP truly "captured the essence" of the client, stating "she (AP) knew the client well and was a good nurse for him."

During an interview, the AP stated she saw the client on a regular basis.

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: No. Unable to interview due to his cognitive status.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility routinely ensured the client was seen daily by nursing staff.

Action taken by the Minnesota Department of Health:
No action required.

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
	H26443	A. BUILDING: _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILES VENTS INCORPORATED	5701 SHINGLE CREEK PKWY #115 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	Initial Comments On May 30, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL264438222C/#HL264431020M. No correction orders are issued.	0 000		