Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL264431021M
Compliance #: HL264438223C

Date Concluded: June 20, 2024

Name, Address, and County of Licensee Investigated:
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 neglected the client when they failed to ensure a facility nurse conducted in-person nursing visits to ensure the client was safe.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility nurse stated the client's family member routinely updated her regarding the client's doctor's appointments and the client's condition. The client's family member, a licensed practical nurse (LPN), was employed by the facility as a personal care attendant (PCA) and provided daily cares for the client. In addition, law enforcement performed a wellness check on the client and confirmed the client was safe.

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

The client received comprehensive home care services in their home. The client's diagnoses included anoxic (caused by lack of oxygen) brain injury. The client's record indicated the client received assistance with activities of daily living (ADL)'s, medication management, meals, transfers, and mobility. The client was unable to walk and used a wheelchair for mobility. The client was oriented to person, place, and time.

During the winter of 2023, the client's record indicated the facility nurse contacted the client's family member to ask permission for a state surveyor to conduct an observation visit. The facility made multiple attempts to reach the family by phone but was unable to contact the family member. The next day the facility contacted the family who refused a state surveyor visit but allowed the facility manager to visit the home. That day, the client was not seen by the facility manager. The facility nurse stated the last time she "laid eyes" on the client was a year prior to the request for the on-site visit. The client's record indicated concerns arose on the client's safety.

Review of a police report indicated three days later; law enforcement attempted to perform a wellness check at the client's home but left after no one answered their knocks at the client's front door. A few days later, law enforcement returned to the client's home and visually saw the client was safe.

During an interview, the facility nurse stated she saw the client in December 2023 but was unsure of the date.

During an interview, the client's family member stated she always updated the facility nurse regarding the client. The family member stated she was upset when law enforcement showed up at their home at the end of December 2023 to perform a welfare check. The client's family member stated law enforcement went to the client's room to check on the client then left. The client's family member stated she did not want visitors at their home because of concerns with Covid, stating, "we (client) and I both got Covid bad."

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 their cognitive status.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No.

Action taken by facility:
No further action required.

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
	H26443	A. BUILDING: _____ B. WING _____	C 05/29/2024

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 29, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL264438223C/#HL264431021M. No correction orders are issued.	0 000		