Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL327302721M
Compliance #: HL327302172C

Date Concluded: August 26, 2024

Name, Address, and County of Licensee Investigated:
Stanton House W Services Inc
4847 Bryant Avenue North
Minneapolis, MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, 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 resident when the resident smoked while wearing oxygen.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility assessed the resident for areas of vulnerability and put interventions into place 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 record, facility documentation, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included pulmonary hypertension, chronic obstructive pulmonary disorder (COPD), and atrial fibrillation. The

resident's service plan included assistance with respiratory equipment, mobility, and medication management. The resident's assessment indicated the resident was cognitively intact and able to communicate her needs.

Complaint documents indicated the day the resident moved into the facility, the resident smoked with her oxygen in use. When the resident was told it was not safe, the resident stated she did not care but turned the oxygen valve off.

Facility nursing staff completed a smoking assessment upon the resident's admission to the facility. The assessment directed staff to turn off the oxygen prior to bringing the resident outside to smoke and to monitor the resident when smoking to ensure her safety.

During an interview, facility staff stated the resident quit smoking during her stay at the facility. Facility staff stated if the resident smoked again or wanted to smoke again they would update the facility nurse.

During an interview, facility management stated the day the resident moved into the facility she smoked while wearing her oxygen and wasn't used to living in a facility with rules. Facility management provided education to the resident regarding safety. The resident decided to quit smoking on her own and had not smoked in over a month. Facility management stated staff were educated that smoking with oxygen in use was not a safe practice and they were instructed to call the nurse and the nurse would assist if needed. Facility management stated the resident was doing very well since moving into the facility. Facility management stated if the resident started to smoke again, they would turn the oxygen off, document the incident, provide education, and notify the primary care provider.

During an interview, the resident stated she no longer smoked and quit about four months ago. The resident stated there wasn't a concern about smoking with her oxygen on because she quit. The resident had no concerns with the facility.

During an interview, a family member stated the resident told her she quit smoking prior to moving into the facility. The family member had no concerns about the care provided by the facility.

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: Not Applicable.

Action taken by facility:
The facility assessed the resident, implemented interventions, and provided education to the staff and resident.

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
	32730	A. BUILDING: _____ B. WING _____	C 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON HOUSE W SERVICES INC	4847 BRYANT AVENUE NORTH MINNEAPOLIS, 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 July 16, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL327302172C/#HL327302721M. No correction orders are issued.	0 000		