Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL360581300M
Compliance #: HL360588765C

Date Concluded: May 29, 2024

Name, Address, and County of Licensee Investigated:
Skyblu Residential Services
9121 Barrington Terrace
Brooklyn Park, MN, 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, 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 staff failed to provide the resident supervision. While the resident was out in the community the resident stole a knife, self-inflicted a wound, and required 12 stiches.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident was assessed as safe unsupervised in the community four hours a day. The facility staff followed the care planned interventions for room searches for sharp objects however, despite the searches and during the unsupervised time, the resident obtained a pocketknife and cut his left forearm requiring stiches to close the wound.

The investigator conducted interviews with facility staff members, including administrative staff. The investigation included review of the resident records, facility internal investigation,

and incident reports. Also, the investigator observed the resident and the facility's locked storage of sharp items.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia, traumatic brain injury, and self-injurious behaviors. The resident's care plan included random room checks for removal of items that posed a possible threat to the resident. The resident was allowed four hours of unsupervised time in the community which were used to walk to the park or to stores. The resident's possession restriction plan indicated the resident was not to have sharp items in his room due to a history of self-injury. The resident was alert and oriented with delusional ideation.

The facility internal investigation indicated the day of incident the resident had eaten and walked to his room. Ten minutes later, staff heard a noise. The resident came out of his room and told staff he had cut himself. The resident said, "see I have cut myself I can now get my medication because I have cancer; they are going to give me what I want now." The resident was calm during the interaction. Staff provided first aid and called 911. The resident said he used a pocketknife stolen from the tobacco store the day before and hid it inside his pillowcase and inside the belt area of his pants. The police removed the pocketknife, and emergency medical services transported the resident to the hospital.

Staff on shift and staff on prior shifts were interviewed. Staff reported there were no changes in the resident's daily routine. Staff did a room search prior to the resident's return from the hospital. No other knives or sharp objects were found. The resident said he cut himself due to a bet and then said he cut himself because he wanted medications his providers refused to prescribe him. The resident returned to the facility from the hospital after receiving 12 stiches.

During an interview, leadership stated due the resident's history of self-injurious behaviors prior to admission to the facility, the resident had a possession of sharp objects restrictions. The day of the incident the resident was calm, relaxed, and did not display behaviors that staff could have anticipated the resident would self-inflict an injury or that he had a pocketknife. The resident had just eaten and went to his room. About 10 minutes later, the resident came out of his room and showed staff the cut on his left forearm. Staff provided first aid and called 911. The resident had conflicting accounts as to how he obtained the pocketknife. The resident said during the unsupervised time in the community, he stole the pocketknife from a tobacco store and also said he had found the knife while walking outside. The resident said he hid the knife in his belt area of his pants. Leadership stated the resident had no other incidents of self-inflicted injury at the facility. Sharp items were not accessible to the resident. The facility conducted ongoing room searches on all the residents prior to the incident and continued to conduct room searches for sharp objects or objects that could be used for harm after the incident. Items found were removed and put in the facility locked storage area.

During an interview, the resident stated staff checked on him, were available if he needed assistance, and conducted room checks for sharp items.

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: No. Responsible for self.
Alleged Perpetrator interviewed: No.

Action taken by facility:
The facility staff provided first aid and called emergency medical services. After the incident, the facility conducted an immediate room search, conducted an internal investigation, conducted an assessment, and added additional interventions.

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
	36058	A. BUILDING: _____ B. WING _____	C 05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYBLU RESIDENTIAL SERVICES	9121 BARRINGTON TERRACE BROOKLYN PARK, MN 55443

(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 21, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL360588765C/#HL360581300M. No correction orders are issued.	0 000		