DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL35670001M
Compliance #: HL35760002C

Date Concluded: August 11, 2022

Name, Address, and County of Licensee Investigated:
Global Alliance Home Health
4833 Winnetka Avenue North
Crystal, MN 55428
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: James Larson RN
Special Investigator

Finding: Inconclusive

Nature of Visit:
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 supervision and the resident was started a fire in her room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although a fire had occurred, it was an unforeseen and isolated incident, and the resident sustained no harm. Following the incident, facility staff assessed, monitored, and implemented additional interventions to ensure the resident's safety.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff. The investigator also contacted law enforcement. The investigation included review of the resident's medical record, nursing assessments, service plans, care plans and progress notes. Also, the investigator observed staff interaction with residents.

The resident's medical record included the resident had diagnoses of depression, bipolar disorder, and fetal alcohol syndrome. The medical record further indicated the resident had intellectual disability, altered mental status and history of theft of property. The resident's service plan included assistance with meals, medication management, housekeeping, and laundry. The resident was not permitted to smoke or have lighters or matches and was only to be allowed to smoke cigarettes outside the facility in a designated area.

The day the incident occurred, the resident had voiced suicidal statements to staff and was transported to a local hospital for evaluation. The resident returned to the facility later that day. Upon her return, the resident went to her room following a verbal altercation with staff. Shortly thereafter, staff members were alerted to smoke coming from behind the closed door of the resident's room. Upon entering the room, staff found what appeared to be burnt carpet and a blanket smoldering on the floor. Staff put out the fire, removed the resident from the room and contacted police. The resident was transported by police to the hospital for further evaluation.

During an interview with a police officer who responded to the call, they stated that upon entering the resident's room a cigarette lighter was found and confiscated. The officer spoke with the resident who agreed to leave the room unassisted.

During an interview, the guardian of the resident stated they were aware of the incident and had no concerns about the care provided by the facility.

The resident recalled the incident and stated she should not have started a fire in her room. The resident acknowledged the facility implemented new safety measures following the incident and had an agreement with the facility to not keep fire making items in her room. The resident indicated she had received appropriate care and felt safe residing at the facility.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) 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.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.
(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:
(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or
(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; or
(2) the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult;
(3) the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:
(i) a person including a facility staff person when a consensual sexual personal relationship existed prior to the caregiving relationship; or
(ii) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship; or
(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and

(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility increased services, including safety checks, for the resident in consultation with the resident and guardian.

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
	35670	A. BUILDING: _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLOBAL ALLIANCE HOME HEALTH	4833 WINNETKA AVENUE NORTH CRYSTAL, MN 55428

(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 Initial comments On June 29, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL35670002C/#HL35670001M. No correction orders are issued.	0 000		