Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL351289825M
Compliance #: HL351287740C

Date Concluded: May 21, 2024

Name, Address, and County of Licensee Investigated:
Christian Homes
295 12th Street
Newport, MN 55055
Washington County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Deb Schillinger 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 facility left the resident unsupervised and was found mixing unknown chemicals in the microwave.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility was following the resident's plan of care at the time the incident occurred. The facility staff immediately called 911 and the resident was sent to the hospital for evaluation of health status.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's guardian. The investigation included review of the resident record, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator made an onsite visit, toured the facility and observed staff to resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included paranoid schizophrenia. The resident's service plan included supervision and medication management. The resident's assessment indicated the resident walked independently and needed daily reminders to complete self-care.

The facility incident report indicated staff member(s) noticed a chemical odor and found the resident mixing unknown chemicals in the microwave. The form also indicated the facility called 911 was called and the resident was transferred by emergency medical services to hospital for an evaluation.

The facility internal investigation stated medications were found in the resident's pockets indicating the resident had skipped taking his medication without the unlicensed caregivers knowledge.

During an interview, the nurse stated the resident was found in the home mixing unknown chemicals in the microwave, causing fumes and was sent to hospital for evaluation. Upon return the facility began providing closer supervision, which was implemented. The facility determined the resident had purchased the chemicals he put the microwave and implemented steps to monitor the items he brings into the facility.

During an interview, the resident stated he purchased chemicals independently and brought them into the residence. He denied having any chemicals in the home.

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.
(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;

(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 the

Action taken by facility:
Resident was transferred to hospital for evaluation, chemicals and cleaning products placed in locked cabinet and the resident must show staff what he is bringing into the residence.

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
	35128	A. BUILDING: _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN HOMES	295 12TH STREET NEWPORT, MN 55055

(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 April 24, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL351287740C/#HL351289825M. No correction orders are issued.	0 000		