Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL215373382M
Compliance #: HL215373516C

Date Concluded: October 7, 2024

Name, Address, and County of Licensee Investigated:
Global Home Health Care Inc
1032 15th Avenue SE
Rochester, MN 55904
Olmstead County

Facility Type: Home Care Provider

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, individual responsibility

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):
An agency staff member/alleged perpetrator (AP) neglected the client when she violated the agency's policies and procedures and allowed her boyfriend to drive the client to run errands. The boyfriend crossed a center line while driving and got into a head on collision with a semi-trailer. The client was taken to the hospital for further evaluation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The agency had a policy prohibiting staff from driving clients in their personal vehicles and a policy that prohibited staff from having non-employees in client homes. The AP allowed her boyfriend to drive her and the client to run errands and got into an accident. The AP's boyfriend was under the influence of marijuana at the time of the crash was charged with fourth degree DWI [driving while intoxicated] and criminal vehicular operation causing substantial bodily harm.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the case manager. The investigation included review of the client's records, hospital records, facility internal investigation documentation, facility incident reports, personnel files, law enforcement reports, and related facility policies and procedures.

The client received comprehensive home care services in their home. The client's diagnoses included traumatic brain injury and short-term memory loss. The client's service plan included assistance with cleaning the client's kitchen, monitoring food for freshness, taking out garbage, changing bed linens, and household cleaning. The client's service plan did not include assistance with transportation. Any transportation needs were to be coordinated with the client's case manager. The client's assessment indicated the client received household management and home making services for up to ten hours per week.

The AP's employee record indicated she was trained on the client's plan of care and agency policies and procedures. The AP received training which indicated bringing friends, family, or pets to a client's home was not permitted at any time.

The facility's internal investigation indicated the AP clocked into work at 12:29 p.m., shortly before the accident occurred. The AP confirmed her boyfriend occasionally drove her and the client to various location. The investigation indicated the AP "grossly violated" the company's transportation and HIPPA policy by bringing her boyfriend to the workplace and providing transportation to the client.

The police report indicated law enforcement officers were dispatched for a report of a motor vehicle crash with injuries at 12:52 p.m. There was a three-vehicle crash and the AP's boyfriend was under investigation for criminal vehicular operation. Vehicle one (driven by the AP's boyfriend) was traveling eastbound and vehicle two, a semi-truck with a trailer, was traveling westbound. Vehicle three was legally parked on the north side of the road facing west. A witness stated vehicle one began slowly drifting across the center line into westbound traffic and collided with the semi-truck driver's side and continued striking the semi-trailer attached. The trailer's wheel axles became disconnected and struck vehicle three. Vehicle one sustained "heavy damage," the semi-truck had "minor damage," but the trailer sustained "heavy damage." Vehicle three had moderate damage to the passenger rear side.

The police report indicated law enforcement officers smelled marijuana coming from the vehicle and a pipe and bag of marijuana were located inside the driver's side door. The AP's boyfriend stated he blacked out. Officers noted the AP's boyfriend's speech appeared slow and sluggish and his eyes were glossy. He admitted to smoking marijuana inside the vehicle around 9:30 that morning and admitted to possession of the pipe and bag of marijuana. A toxicology report confirmed the presence of marijuana in the AP's boyfriend's system, and he was charged

with fourth degree DWI [driving while intoxicated] and criminal vehicular operation causing substantial bodily harm.

Hospital records indicated the client was seen at the hospital after the crash for “trauma to chest and left sided tenderness.” No fractures or other concerns were noted. The client was evaluated and discharged the same day. The client returned to urgent care the next day for left chest tenderness and was diagnosed with a chest wall bruise. The client was instructed to use ice and take Tylenol.

During an interview, the client stated it was common for the AP’s boyfriend to drive him and the AP places while she provided services at his home, and they would go out about once a week. The client didn’t realize that employees were not to drive or transport clients in their personal vehicles. The client stated he was in the passenger side of the car and the AP’s boyfriend was driving when the car crossed the center line and hit a semi-trailer. The client was not aware the AP’s boyfriend was under the influence of marijuana while driving.

During an interview, the AP stated they went to run errands that day because the client wanted to go shopping, so she had her boyfriend drive them. The AP stated she didn’t remember anything that happened after the crash but that her boyfriend coughed and sneezed so hard he blacked out and that’s when he hit the semi-trailer head on. The AP stated she didn’t know if it was approved for her boyfriend to drive the client but stated the facility knew about it because she did not have a vehicle. The AP stated the client had bus transportation, but it took forever to wait for it and then they had to transfer between busses. The AP stated she was not aware her boyfriend used marijuana the day of the incident and thought he had quit a few years ago.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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: Not applicable

Alleged Perpetrator interviewed: Yes

Action taken by facility:
The agency retrained the AP.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Winona County Attorney
Winona City Attorney
Winona Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21537	A. BUILDING: _____ B. WING _____	C 09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLOBAL HOME HEALTH CARE INC	1032 15TH AVE SE ROCHESTER, MN 55904

(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 ******ATTENTION****** HOME CARE PROVIDER PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL215373382M/#HL215373516C On September 9, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there was one client receiving services under the provider's Comprehensive license. The following correction order is issued for #HL215373382M/#HL215373516C tag identification 0325.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2).	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment be free from physical and verbal abuse, neglect,	0 325		

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0 325	Continued From page 1 financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act This MN Requirement is not met as evidenced by: The facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual was responsible for the maltreatment, in connection with incidents which occurred at the agency. Please refer to the public maltreatment report for details.	0 325	No plan of correction required for this tag.	