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 #: HL395532202M
Compliance #: HL395533771C

Date Concluded: July 2, 2025

Name, Address, and County of Licensee Investigated:
Homefelt Assisted Living
1132 Adams St NE
Minneapolis, MN 55413
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, RN, BSN, 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 a resident when the resident was smoking in her room with supplemental oxygen in use and the supplemental oxygen caught fire.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. When the resident resumed the use of smoking cigarettes, the facility assessed and provided education to the resident on the dangers of smoking with oxygen in use. Despite the education, the resident smoked a cigarette using oxygen in her apartment that caused a fire. The error was an isolated and unforeseen incident. The resident sustained third degree burns to her face, she received treatment and returned to their baseline health condition.

The investigator conducted interviews with facility staff members, including, nursing staff, and unlicensed staff. The investigator contacted the case worker. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports,

staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included idiopathic pulmonary fibrosis (a chronic lung disease characterized by the progressive scarring (fibrosis) of the lungs, with an unknown cause), schizophrenia, bipolar type, borderline personality disorder, and nicotine dependence. The resident's service plan included assistance with oxygen delivery, safety checks, and self-injurious behaviors. The resident's assessment indicated the resident had intact cognition and walked and transferred independently. The resident's assessment indicated the resident had a history of smoking and using a vape (a device used for inhaling vapor containing nicotine and flavoring), but was not smoking or using a vape at the time of the assessment.

A progress note indicated approximately one month after the resident's assessment was completed, staff reported the resident was smoking. Licensed staff provided education to the resident about the dangers of smoking with the use of oxygen and the resident agreed to only smoke outside of the facility without the oxygen.

An incident report indicated three weeks after the progress note, the resident sustained a burn to the face from a fire from the supplement oxygen in her room. Emergency services was called, and the resident was transferred to the hospital.

Hospital records indicated the resident sustained third degree burns to the face. The resident was lighting a cigarette while wearing oxygen when there was flash fire. The resident was hospitalized for eight days and returned to the facility.

During an interview, unlicensed personnel stated the day of the incident, the resident came running out of her room with her hair on fire. The unlicensed personnel stated they distinguished the flames and instructed another staff member to take the residents outside of the facility. Inside the resident's room, a blanket was on fire and was extinguished when a cigarette butt fell out of the blanket. The oxygen tubing was also on fire and was extinguished. The other staff member called emergency services, and the resident was transported to the hospital. The unlicensed personnel stated the resident was aware that she was to take her oxygen off and smoke outside of the facility.

During an interview, a nurse stated after the resident resumed smoking, education was provided about smoking and using supplemental oxygen. The resident stated she understood the dangers. The nurse stated there were no prior incidences of the resident smoking in her room or smoking while wearing oxygen. The nurse stated following the hospital discharge, the facility had a care conference with the resident and education was again provided to the resident about the seriousness of smoking with oxygen. The nurse stated staff were also educated to observe the resident's room for cigarettes and lighters.

During an interview, the resident stated she only wanted a couple puffs from a cigarette and forgot she had her oxygen on, and it caught fire. The facility had provided education on the dangers of smoking while using supplemental oxygen. The resident stated she was aware of the dangers and no longer smoked.

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. Resident was responsible for self.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Staff evacuated residents out of the facility and extinguished the fired. Emergency services was called, and the resident was transported to the hospital.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39553	A. BUILDING: ______ B. WING ______	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEFELT ASSISTED LIVING LLC	1132 ADAMS STREET NORTHEAST MINNEAPOLIS, MN 55413

(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 June 16, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL395532202M/#HL395533771C. No correction orders are issued.	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE