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 #: HL261213408M
Compliance #: HL261215677C

Date Concluded: January 17, 2023

Name, Address, and County of Licensee Investigated:
Vista Prairie at Copperleaf LL
1550 1st Street North
Willmar, MN 56201
Kandiyohi County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name:
Lisa Coil, RN Special Investigator

Finding: Substantiated, facility 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):
The alleged perpetrator neglected the resident when the alleged perpetrator failed to follow the residents care plan and gave the resident coffee in a ceramic coffee cup. The resident suffered burns to his fingers and ended up with a right ring finger amputation due to the burn.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. When the resident sustained burns to his left hand from a hot coffee cup, the facility did not put interventions in place to prevent the risk of recurrence. Three weeks later the resident's right hand sustained burns from a hot coffee cup, which eventually led to an amputation of one of the resident's fingers on his right hand.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member and

the resident's provider. The investigation included review of the resident's facility record and facility's internal investigation. Also, the investigator observed staff to resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included dementia, type 2 diabetes, and neuropathy (damage to the nerves that cause weakness, tingling, and numbness). The resident's service plan included meal services but did not identify if the resident needed specific assistance. The resident's assessment indicated he ate independently following set-up which may include cutting up foods at times. The assessment indicated the resident had mild memory and thinking problems and a history of disorientation. The assessment further indicated the resident had numbness or tingling in extremities and neuropathy in hands and feet.

The facility internal investigation, completed approximately seven weeks following the initial incident, indicated the resident was served hot coffee in a blue ceramic coffee mug during lunch. The resident was holding the coffee mug which injured his hand, although which hand was not specified. The document indicated the wound was a "reinjury" but did not specify what previous injury it was referring to. The document indicated the coffee mug was replaced with a silver insulated coffee mug, but it did not specify when the replacement took place.

Injury #1

The progress notes indicated the resident was handed a ceramic coffee cup and sustained burns on three of his fingers on the *left* hand. The same note indicated the resident's medical provider would be updated at her next visit on "Friday" [the documents indicated the burn occurred on a Wednesday]. The note indicated the staff were told to use an insulated cup. The facility's electronic medical record showed this was a late entry on the same day the facility's internal investigation was dated (approximately seven weeks later).

Two days after the resident sustained the burns on his left hand the medical provider notes indicated she saw the resident who had second degree burns with blisters on three fingers on his left hand. The medical provider wrote orders for wound care.

Injury #2

Approximately three weeks after injury #1 the progress notes indicated the resident was handed a ceramic cup and sustained blisters to his right hand. The facility's electronic medical record showed this was a late entry on the same day the facility's internal investigation was dated (approximately four weeks after injury #2).

Two days later the medical provider notes indicated the resident had second degree burns on the fingers of his right hand. The same note indicated the medical provider discussed with staff to consider an insulated coffee mug to prevent burns. The medical provider also documented the resident had neuropathy in both hands and did not feel when his fingers were burning on a

hot coffee mug. The same note indicated the burns on the residents left hand were still present. The note was dated more than three weeks after the initial injury to the resident's left hand.

Subsequent notes from the medical provider indicated she ordered a referral for a wound clinic as healing was complicated by the resident's impaired thinking and memory and he had a tendency to pick at his wounds.

Infection and Amputation

Approximately three weeks after the residents second injury, the resident's right hand developed an infection and the resident received antibiotics.

During this same week, the wound clinic determined the wound had worsened and, after a hand surgeon was consulted, an amputation of one of the resident's right fingers was planned related to a "full thickness" burn. The resident admitted to the hospital for the amputation and returned to the facility following a hospital stay.

A review of the resident's medical record did not identify the facility updated the resident's care plan to include the use of an insulated coffee mug after injury #1 occurred to the resident's left hand and prior to recurrence of a similar injury to the resident's right hand.

During an interview, an activities assistant stated it was part of his job to assist with serving drinks and meals to the resident at mealtimes. The activities assistant stated on the day of the incident (injury #1) he served the resident coffee prior to the meal. The activities assistant stated the resident used a special coffee mug, which was at the table when he served the coffee. The activities assistant stated the resident had a couple of different coffee mugs but the one he used the day of the incident was brown with no handle and had a lid.

During an interview, the nurse stated following training, activities assistants were able to serve beverages at meals times. The nurse stated staff, including activities assistants, were able to see if a resident used adaptive equipment by viewing their care plan. The nurse stated the resident used an insulated mug with a handle, but she did not think it always had to be used. The nurse stated she was unsure whether the insulated mug was on the resident's care plan at the time of the incident (injury #1) but was sure one of the other nurses put it on the resident's care plan following the incident. The nurse stated she did not discuss the incident with the activity assistant but reported it to their direct supervisor and a member of management who would have been responsible to follow up with them. The nurse further stated nursing staff were re-educated at a staff meeting three to four weeks following the incident; however, there was information posted electronically prior to the meeting. The nurse thought the resident burned his right hand during this incident and could not recall if there was a second burn incident which caused burns to the other hand.

During an interview, a member of management stated the resident had a special coffee cup that went everywhere with him. The cup was big so the resident could hold it better, but the member of management could not recall what it looked like. The member of management stated she was not in the facility when the incident (injury #1) occurred but understood the incident was witnessed by staff, staff intervened, the nurse practitioner got involved for treatment right away, and the burn was to the resident's right hand. The member of management stated the resident started using an insulated coffee mug following the incident but was unsure whether the information was added to his care plan. When discussing the resident's documentation, the member of management stated the nurse practitioner put in the incorrect information at first because it was the resident's right hand that got burned. With further discussion regarding documentation in the resident's record, the member of management denied a second burn incident and stated, "I only recall a right-hand burn."

During an interview, the resident's medical provider stated the resident obtained burn injuries to fingers on both hands in two separate incidents. In the first incident, the resident burned three fingers on his left hand. In the second incident, the resident burned fingers on his right hand and reinjured the burns to his left hand, making them worse.

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: No. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility notified the provider and treated the burns.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26121	A. BUILDING: ______ B. WING ______	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE AT COPPERLEAF	1550 1ST STREET NORTH WILLMAR, MN 56201

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95, 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: #HL261215677C/#HL261213408M On November 2, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 83 residents receiving services under the provider ' s Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL261215677C/#HL261213408M, tag identification 2360.	0 000	No plan of correction is required for this tag.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment.	02360	No plan of correction is required for this tag.	

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26121	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE AT COPPERLEAF	**1550 1ST STREET NORTH WILLMAR, MN 56201**

(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
02360	Continued From page 1 Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		