Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL282094364M
Compliance #: HL282097395C

Date Concluded: February 28, 2023

Name, Address, and County of Licensee Investigated:

Birchview Gardens Assisted Living
108 3rd Street North
Hackensack, MN 56452

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

Evaluator's Name:
Jana Wegener, RN - Special Investigator

Finding: Substantiated, facility responsibility

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 a resident when they failed to ensure the resident could safely drink coffee after the resident repeatedly spilled coffee on herself causing blistering burns.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident spilled hot coffee on herself resulting in blistering and the resident was sent to the hospital for treatment. The facility failed to assess

the resident to ensure interventions were in place to prevent the resident from burning herself with hot coffee. Approximately three weeks later, the resident spilled coffee on herself again which resulted in blistering burns.

The investigator conducted interviews with facility staff members, including administrative, nursing, and unlicensed staff. The investigation included review of the resident's medical record, facility incident reports, employee records, and facility policy and procedures. Observations were made of the resident's room and staff/ resident interaction.

The resident resided in an assisted living facility with diagnoses including anoxic brain injury and a seizure disorder. The resident's service plan indicated the resident required assistance with activities of daily living including dressing, toileting, transfers, and repositioning.

The resident's assessment indicated the resident had impaired judgment due to an anoxic brain injury causing encephalopathy (a disease of the brain). The resident required close supervision and had short term memory issues related to traumatic brain injury and was occasionally disoriented. The assessment identified the resident was at risk for burns when smoking due to jerking movements and the resident was to refrain from smoking if she was having jerking symptoms. Although the resident had a history of burning herself with coffee, the resident's assessment failed to identify the risk for the resident burning herself with hot coffee related to jerking movements, impaired judgment, or disorientation.

A facility incident report indicated the resident had spilled coffee on her abdomen causing a burn.
The residents progress notes of the incident indicated the resident had spilled hot coffee resulting in two burns on her left lower abdomen; one was the size of a silver dollar, and the other was the size of a quarter. The progress note indicated the resident's skin was peeled but there was no blistering.

The following day the residents progress notes indicated when a nurse assessed the resident's burns from the previous day, they discovered the resident had a new coffee burn on her left thigh. The note indicated the burns were now blistered, weeping, and appeared worse than the previous day. The resident was transferred by ambulance to the emergency department for evaluation and treatment.

Approximately three weeks later another incident report indicated the resident had three new coffee burns on her right abdomen and on the right inner thigh that were blistered. The report indicated burn number one was blistered and measured approximately two inches long by a quarter of an inch wide; burn number two was blistered and measured two inches long by a quarter of an inch wide; and burn number three was three and a half inches wide with a torn blister. The incident report indicated the blister stuck to the resident's pants and tore open when the residents clothing was removed. The facility called 911 but the resident refused transport to the hospital.

When interviewed, facility staff stated the resident had heated up coffee in her microwave in her room, jerked, and spilled coffee on herself causing the burns.

When interviewed nursing staff stated they did not assess the resident's ability to safely operate the microwave after the first burns occurred, and no interventions were put in place to prevent recurrence.

When interviewed nursing leadership indicated they felt the initial coffee burn was an isolated incident and the resident had no history of burning herself by spilling coffee.

In conclusion, 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:
(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.

Vulnerable Adult interviewed: No, declined
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility provided wound care, and the resident's burns healed. The facility unplugged the resident's stove and microwave and removed the resident's coffee pot.

Action taken by the Minnesota Department of Health:

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 651-201-4890 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
Cass County Attorney
Hackensack City Attorney
Hackensack Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28209	A. BUILDING: _____ B. WING _____	C 02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

(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****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: #HL282094364M/ #HL282097395C On February 21, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders were issued. At the time of the complaint investigation, there were 36 residents receiving services under the provider's Assisted Living with Dementia care license. The following correction order is issued HL282094364M, and HL282097395C, tag identification 2360.	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 Assisted Living License 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 144G.31 subd. 1, 2, and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 1 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure one of one of one residents reviewed, (R1) was free from maltreatment. R1 was neglected. 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. No plan of correction is required for this tag.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report for details of this tag.	