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 #: HL287902580M
Compliance #: HL287901751C

Date Concluded: June 17, 2024

Name, Address, and County of Licensee Investigated:
Towerlight on Wooddale Avenue
3601 Wooddale Avenue South
St. Louis Park, MN 55416
Hennepin County

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

Evaluator's Name:
Maerin Renee, 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 a portable space heater was placed in the resident's room and the resident burnt her leg. The resident developed a blister on her left shin which required emergency care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident was using a space heater in her room when facility repairs were being completed. The resident had limited sensation in her legs, sat too close to the space heater, and developed a large blister on her left shin. Staff assessed the blister and sent the resident to the hospital for further evaluation. When the resident returned, staff completed dressing changes as ordered and the blister healed. The resident was able to make her needs known and the plan of care was being followed at the time of the incident.

The investigator conducted interviews with the resident and facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff interactions with residents.

The resident resided in an assisted living facility The resident's diagnoses included multiple sclerosis. The resident's service plan included assistance with medication management, transfers, bathing, dressing, laundry, and housekeeping.

The resident's assessment indicated the resident was alert and oriented to person, place, and time, independent with most activities, and used a wheelchair without assistance.

The resident's nursing assessment indicated help with bathing was recommended, but the resident chose an outside provider to help with her activities of daily living (ADLs). The resident was assessed as independent with skin care needs.

The resident's progress notes indicated she received a burn from a space heater, in the form of a fluid-filled blister on her left leg. The resident said her legs felt cold, so she decided to warm them up with the portable space heater. She said she did not feel the burn. The blister was intact and measured approximately 7.5cm x 5.5 cm. The resident's primary care provider and a family member were notified. The resident was sent to the hospital for evaluation and returned the same day with orders for wound care. The wound care alternated between facility staff and home care staff. The wound was described as superficial without drainage or signs/symptoms of infection. The resident did not complain of pain. Two months later the wound was smaller and covered with eschar (dead tissue that forms over healthy skin which will, over time, fall off).

When interviewed, a facility leader said the resident should not have had a space heater in her room. Maintenance staff brought the space heater into the resident's room when they were fixing her heat pump. When maintenance left, they forgot to take the space heater with them. After staff discovered the resident's blister, all space heaters were removed from the building.

When interviewed, a supervisor said she visited the resident due to a change in behavior. The resident was in bed all the time, she was not eating, and she was declining most services. The supervisor talked to the resident and then the resident showed her the blister on the resident's left shin. The supervisor said the blister was about three inches by four inches in diameter and filled with fluid. The resident told her the blister developed three to four days prior and the resident did not want staff to know about it, as she thought she could take care of it herself. The supervisor said they sent the resident to the hospital, and she returned later the same day. Staff and home care provided wound care as ordered.

When interviewed, the resident said she was cold after a shower and snuggled up to the space heater. The resident said due to impaired sensation in her left leg, she did not realize how close she was to the space heater. When she took her leg away, there was a blister. The resident said it was an accident and did not have anything to do with misuse of the space heater.

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, the resident is her own guardian.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility removed the space heater from the resident's room and removed all space heaters from the facility.

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
	28790	A. BUILDING: _____ B. WING _____	C 05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWERLIGHT ON WOODDALE AVENUE	**3601 WOODDALE AVENUE SOUTH SAINT LOUIS PARK, MN 55416**

(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 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: #HL287901751C/#HL287902580M and #HL287907468C/#HL287909645M. On May 14, 2024, 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 71 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL287907468C/#HL287909645M, tag identification 2360.	0 000		
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.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. 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	No plan of correction is required for this tag.	