Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303611321M
Compliance #: HL303612408C

Date Concluded: September 5, 2022

Name, Address, and County of Licensee Investigated:
Arbor Park Living Center LLC
2941 6th Avenue North
Moorhead, MN 56560
Clay County

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

Evaluator's Name: Jill Hagen, RN,
Special Investigator

Finding: Not Substantiated

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 staff failed to ensure the resident was safe to independently smoke. As a result, the resident lit his clothes on fire and sustained burns requiring hospitalization and treatments. In addition, the facility failed to provide the resident with an emergency termination notice and refused to admit the resident following his hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility assessed the resident to be safe smoking independently. One early morning the resident left the facility to smoke and accidently lit a napkin/tissue on fire next to his wheelchair which lit his

clothes on fire. The resident was transported to an acute setting for an evaluation and treatment with deep burns to the right side of his body.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical record, staff schedules, and policies and procedures including assessments. Also, the investigator observed the resident's apartment location and the designated smoking areas.

The resident resided in an assisted living memory care unit. The resident's diagnoses included quadriplegia (partial or full paralysis of the upper and lower body) and alcohol abuse. The resident's service plan included staff assistance to complete all activities of daily living, a mechanical sling lift for transfers, and the resident used an electric wheelchair for all mobility. The resident made his own decisions and not at risk for self-abuse.

The resident's smoking safety assessment completed four months prior to the incident indicated the resident was aware of the outside designated smoking areas, able to obtain and light cigarettes safely and independently, and had no history of burns or injury due to smoking.

Observation of the facility indicated the resident's apartment was located on the first floor of the facility near the back and front door exits of the facility, which were the designated smoking areas.

The facility incident report indicated early one morning, the resident was up most of the night drinking alcohol. The resident became "belligerent" with another resident in the common area of the building. An unlicensed staff directed the resident to his apartment to deescalate the situation. Later, the resident came out of his apartment to the back yard of the facility to have a cigarette. The unlicensed staff heard the resident shout for help when the resident came into the facility with the right side of his clothing and self on fire. The unlicensed staff doused the fire with water. At the time, the resident stated he was out smoking when a tissue/napkin next to his wheelchair caught fire. Initially, the resident refused emergency treatment, but later licensed staff encouraged the resident to be evaluated at a local hospital. The resident required admission to the hospital for treatment of severe burns.

During an interview, management stated prior to the incident, the resident safely obtained and lit his cigarettes using a "torch like" lighter. Management stated the resident's history included alcohol abuse but no safety issues with cigarettes.

Another concern investigated included the facility failing to provide the resident with a four-day emergency discharge notice following his hospital admission and refusing admission of the resident to the facility following his hospital discharge. Even though the facility failed to provide the resident with an emergency discharge notice following four days of hospitalization and refused re-admission to the facility, neither action met the definition of neglect. The resident

did return to the facility following an appeal initiated by the resident's advocate and the resident.

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: No, attempted and refused.
Family/Responsible Party interviewed: No, resident own responsible party.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Following the resident admission to the facility, licensed staff completed assessments including a smoking assessment to include staff supervision when smoking.

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
	30361	A. BUILDING: _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR PARK LIVING CENTER LLC	2921 6TH AVENUE NORTH MOORHEAD, MN 56560

(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 Initial comments ******ATTENTION****** ****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction order is 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: #HL303612408C/#HL303611321M #HL303613259C/#HL303611741M #HL303613930C/#HL303612262M On August 3, 2022, 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 were 40 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL303613930C/#HL303612262M, tag identification 2360.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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: Based on interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On August 3, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred. No plan of correction is required for tag 2360. Please refer to the public maltreatment report for details.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	