Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL335245063M
Compliance #: HL335248676C

Date Concluded: October 16, 2023

Name, Address, and County of Licensee Investigated:
The Moments
16258 Kenyon Ave
Lakeville, MN 55044
Dakota County

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

Evaluator's Name: Danyell Eccleston, 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 facility neglected a resident when the facility provided scalding hot water to the resident. The water spilled and the resident sustained blistering burns to her chest and stomach.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility approved a resident activity that included hot beverages given out at high temperatures, away from areas where residents could easily set the drink down, and without a clear process regarding serving hot liquids. The resident was served hot tea and spilled the tea down her chest. The resident received blistering burns on her abdomen and chest.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease, dermatitis, and speaking disorder due to brain damage. The resident's service plan included assistance with wound care, medication management, mobility and

walking, escorts, and orientation. The resident's assessment indicated the resident had occasional difficulty communicating, following instructions, and remembering and using information. The assessment also indicated the resident required an assistive mobility device and propelled herself in a wheelchair.

The resident's progress notes indicated the resident spilled hot tea down her chest. Staff applied cold packs to the burns and gave pain medication to the resident. Upon further assessment, nurses noted the resident had burns on both breasts and abdomen, and blistered burns to areas on the abdomen and under the left breast. Nurses contacted the resident's medical provider to obtain wound care orders for the resident.

Review of a staff bulletin after the incident indicated hot beverages should not be served at temperatures exceeding 135 degrees and only culinary staff should serve hot beverages. The bulletin stated water from the coffee machine came out at over 190 degrees and could cause severe harm if not brought down to safe temperature.

During investigative interviews, multiple staff members stated after the incident staff were directed to use thermometers to check the hot water temperature, and signs were posted next to hot water faucets to make individuals aware of appropriate water temperatures.

During interview, an unlicensed staff member stated residents were sitting in an area without ample areas to set down beverages during a hot tea activity when the incident occurred. The staff member stated a carafe of hot water and plastic cups from the kitchen were provided to offer tea to residents. The staff member stated she gave the resident a cup of hot tea and then left the area to obtain plain water for some other residents. The staff member stated she was returning to the activity when she heard yelling. The resident spilled her cup of hot tea on herself and was crying out. The staff member stated she requested nurse assistance for the resident.

During interview, an unlicensed staff stated the tea event was the first-time residents were served hot beverages as part of an activity. After the incident occurred activity staff ended the hot tea activity. Since the incident, in addition to signage and thermometers posted at hot water taps, hot drinks are no longer served at activities and any activity involving food or drink is held in the dining room at tables.

During interview, a nurse stated staff called her to the resident's apartment when hot water spilled on the resident during a hot tea activity. The nurse stated the resident was in a panic and breathing rapidly when she arrived at the resident's apartment. The nurse stated she assisted the resident and put cool water and ice on her burns and the burn areas were very red and blistered.

During interview, a family member of the resident stated the resident's burns were red and weepy and the resident would grimace and cry anytime the wounds were touched.

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, vulnerable adult deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility conducted an internal review of the incident and implemented changes to procedures regarding hot water usage for beverages and planned activities.

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 651-201-4200 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
Dakota County Attorney
Lakeville City Attorney
Lakeville Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33524	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOMENTS OF LAKEVILLE	16258 KENYON AVENUE LAKEVILLE, MN 55044

(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: #HL335248676C/#HL335245063M On September 19, 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 89 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL335248676C/#HL335245063M, 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(s) 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.	