Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL341507342M
Compliance #: HL341502481C

Date Concluded: January 10, 2025

Name, Address, and County of Licensee Investigated:

Harrison Bay Senior Living
1861 Commerce Boulevard 218
Mound, MN 55364
Hennepin County

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

Evaluator's Name: Lena Gangestad, 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 she was found with a palm-sized blister on her left lower back, along with smaller open blisters on the sides of the larger blister, caused by a heating pad.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident used her own heating pad without the facility's knowledge. She fell asleep with it on, which caused a burn on her lower back. An unlicensed caregiver noticed the blister and reported it to the triage nurse. The resident was sent to the emergency room for evaluation and returned the same day.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and the resident's family member. The investigation included review of the resident's records, incident reports, staff schedules, policies, and procedures.

The resident resided in an assisted living facility. The resident's diagnoses chronic back pain and dementia. The resident's service plan included assistance of one person with bathing, dressing, housekeeping, medication administration and escorting.

The progress notes indicated one morning an unlicensed caregiver administered pain medication to the resident and observed a large red area on her lower back, along with burn marks and skin blisters. The resident told the unlicensed caregiver that she had left the heating pad on for too long. The unlicensed caregiver reported it to the triage nurse and the resident was sent to the emergency room for evaluation.

The hospital record indicated the resident presented to the emergency department with a burn on the left side of her lower back. The record indicated a history of chronic back pain for which the resident used a heating pad for relief. She fell asleep with the heating pad on, resulting in the burn. The resident was diagnosed with a second-degree burn and was discharged back to the facility in stable condition.

After the resident returned to the facility, the medical provider's orders indicated the resident's wound mupirocin cream (an antibacterial) and barrier cream as needed only.

The home health care notes indicated the resident did not have any active wounds a month after the incident.

During an interview, the resident stated she did not have any concern with her care. She left the heating pad on for too long and fell asleep while it was on. It was the accident. She said the heating pad belonged to her and she no longer uses it. The resident stated the nurse took a good care of the wound and it had healed.

During an interview, a family member stated that the heating pad belonged to the resident and that he had no concerns about the care she received.

During an interview, a manager stated she was unaware the resident was using her own heating pad, as the facility did not allow heating pads in the building. After the incident, the heating pad was removed, and the wound was assessed and treated by medical staff at the hospital. After returning from the hospital, the resident was referred to skilled home nursing visit to provide wound care. The care plan was updated, and the facility educated staff on the prohibition of heating pad use.

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: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The heating pad was removed, and the wound was assessed and treated by medical staff at the hospital. The resident was referred to skilled home nursing visit, and appropriate follow-up care was arranged. The care plan was updated, and staff were educated on the prohibition of heating pad use.

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
	34150	A. BUILDING: _____ B. WING _____	C 01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON BAY SENIOR LIVING	1861 COMMERCE BOULEVARD MOUND, MN 55364

(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 On January 8, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL341507342M/HL341502481C . No correction orders are issued.	0 000		