Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL392997782M
Compliance #: HL392993381C

Date Concluded: March 20, 2025

Name, Address, and County of Licensee Investigated:
Hillcrest Terrace
1507 East 41st Street
Hibbing, MN 55746
St. Louis County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, 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 staff failed to provide adequate supervision. The resident had a candle lit in her room, which started a fire. The resident was evaluated in the emergency room after burning her hand trying to put out the fire.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident was burning a candle that started a fire, the resident had been educated that candles were prohibited in the facility. The resident's service plan was followed. The resident sustained a burn to her hand but was evaluated in the emergency room and returned to her baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the case worker. The investigation included review of the resident record, hospital records, fire department reports, facility internal investigation documentation, facility incident reports, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed the resident's room where the fire started.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder and ADHD. The resident's service plan included assistance with safety checks and medication administration. The resident's assessment indicated the resident was independent with most activities of daily living.

The report from the fire department indicated they were notified of the fire at 2:35 a.m. from an automatic fire alarm. Firefighters observed smoke in the building upon arrival. The building's sprinkler system extinguished the fire. An investigation of the fire indicated the fire likely started from the candle on top of a plastic bin near the television. The fire then ignited a few pictures on the wall and extended to a tv, dresser, plastic bin, and other items around the bin. Several candles were observed in the resident's room.

Hospital records indicated the resident was evaluated for smoke inhalation and a burn to her right hand. The resident reported burning her hand after trying to put out a fire in her room. The resident was diagnosed with first degree burns and partial thickness burns on her hand. The resident was given pain medication and orders to follow up with a burn clinic and discharged back to the facility.

During an interview, two unlicensed personnel (ULP) working the evening shift before the fire happened stated they did not see any candles in the resident's room and had not ever seen candles in the resident's room previously. The ULP working when the fire broke out stated she was cleaning when the fire alarm went off and since she was the only person in the building at the time, she walked through the building to see where the fire was and began assisting residents who were trying to evacuate. The ULP stated emergency responders arrived within minutes, and took over the scene and she didn't see the resident until she was outside.

During an interview, the resident stated she lit the candle and fell asleep and woke up several hours later to smoke in her room. The resident stated she had grabbed the candle and brought it to the sink and during that time, she burned her hand.

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 facility investigated the incident and made a MAARC report.

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
	39299	A. BUILDING: _____ B. WING _____	C 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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 March 5, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL392997782M/#HL392993381C. No correction orders are issued.	0 000		