Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL297911881M
Compliance #: HL297923547C

Date Concluded: October 31, 2022

Name, Address, and County of Licensee Investigated:
Edgewood Blaine LLC
12450 Cloud Drive Northeast
Blaine, MN 55449
Anoka County

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

Evaluator's Name: Willette Shafer, RN
Special Investigator

Finding: Substantiated, individual responsibility

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 alleged perpetrator (AP) neglected the resident when the AP failed to supervise the resident and the resident left the locked memory care unit and was found outside lying on the ground with injuries.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to supervise the resident when the resident left the memory care unit and was found outside lying on the ground with injuries. The resident left the locked memory care unit after holding down the crash bar on the memory care door for an extended period of time, causing the lock to release. The AP failed to attend the sounding alarm when the memory door opened due to emergency release.

The investigator conducted interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement and the resident's family. The investigation included review of medical records, facility policies, incident reports, maintenance records, hospital records, facility internal investigation, and the police report. Also, the investigator toured the facility, observed memory care door operation, and observed interactions between staff and residents.

The resident resided in an assisted living locked memory care unit. The resident's diagnoses included dementia and osteoporosis. The resident's service plan included assistance with bathing, grooming, toileting, medication management, reminders, and supervision. The resident's assessment indicated the resident was at risk for elopement and required 30-minute checks for safety.

According to the law enforcement report, the resident was found lying on the ground outside near a road, arms and face covered in blood, by a visitor. Law enforcement interviewed an unlicensed personnel (ULP) while at the facility. The ULP said staff complete 30-minute safety checks on the memory care residents. The ULP said the AP told her she did not know how long the resident was missing or how long the door alarm sounded.

According to the internal investigation, the Ring (security) camera documented the resident was outside for one hour and 18 minutes. The internal investigation included an interview with the AP and the AP's timeline of events did not match the Ring camera timeline.

During an interview, a nurse said it was reported to her the resident, who lived in the locked memory care unit was found by a visitor laying on the ground outside in the early morning. The nurse said the resident was injured and sent to the hospital. The nurse said she conducted the internal investigation and the AP's interview did not match the Ring camera time of events. The nurse said one staff is assigned to the memory care unit, one staff is assigned to the assisted living unit, and a float staff is assigned to help both units. The nurse said the float staff, spent most of the shift on the assisted living side as there was a resident dying that day. The nurse said the ULP reported to her earlier in the shift, when she delivered medications to the memory care unit, the ULP observed the nurses' station door closed with the lights off. The ULP reported she observed the AP sitting in the chair with another chair pushed up to it, like a bed. The nurse said later that shift the AP came to the assisted living unit and reported the missing resident. The nurse said the AP reported she went to the assisted living side twice before she found the ULP. The nurse said the staff should use walkie talkies to communicate. The nurse said both the AP and the ULP went to memory care to look for the resident but were unable to locate the resident. The nurse said the staff found the resident in the entryway with a visitor.

During an interview, a member of management staff said the AP's timeline did not coincide with the timeline on the Ring camera. The management staff said the AP reported she heard the door alarm sounding 30 minutes after the resident was observed leaving the building on the Ring camera. The management member said the AP changed her timeline after the AP was told

what time the resident was observed on camera leaving the building. The member of management said the AP denied sleeping during the incident.

During an interview, the ULP said the AP walked to the assisted living unit and reported a resident was missing. The ULP said she went to the memory care unit to look for the resident but was unable to find her. She walked to the front of the building and found the resident in the entryway with a visitor. The ULP said earlier in the shift she observed the AP in the nurse's station with the lights off, door closed, sitting with her feet up on another chair, and had headphones in her ears. The ULP said the alarm must have sounded earlier in the shift while she and the hospice nurse were in the resident's room who was dying on the assisted living side, otherwise she would have heard the alarm in the assisted living nurse's station.

During an interview, the maintenance worker said he completed a building tour with new employees during orientation. The maintenance worker said he educated the staff on the memory care door, including that the alarm will sound, and the door will unlock if someone bangs on the door repeatedly or pushes the crash bar long enough. The maintenance worker said he completed the maintenance checks on the doors including holding the crash bar down until the alarm sounds and waits for staff to respond. The maintenance worker said staff know what the alarm means, and staff always responded during these tests. The maintenance worker stated there were no mechanical issues with the memory care door.

During the onsite visit, the memory care door was tested for the investigator. The emergency opening of the door, when the crash bar is held down long enough make a loud audible sound that could be heard loudly throughout the memory care unit.

During an interview, a family member said the facility reported the incident shortly after it happened and reported the police were involved. The family member said the facility set up a care conference with family members to discuss the incident, interventions, and the resident's care plan. The family member said she is satisfied with the facility and the care the resident has received. The family member denied any concerns with the facility.

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, due to cognitive deficit.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, declined interview.

Action taken by facility:
The facility completed an internal investigation and completed re-education with all employees. The facility installed cameras in the nurses' stations. The AP no longer works at the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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
Anoka County Attorney
Blaine City Attorney
Blaine Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29791	A. BUILDING: _____ B. WING _____	C 09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD BLAINE LLC	12450 CLOUD DRIVE NE BLAINE, MN 55449

(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 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: #HL297913547C/#HL297911881M On September 29, 2022, 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 54 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL297913547C/#HL297911881M, tag identification 2360.	0 000	Minnesota Department of Health is documenting 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	Continued From page 1 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. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one residend reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: The Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that an individual staff person 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.	02360	No plan of correction is required for tag 2360. Please refer to the public maltreatment report for details.	