Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306315881M
Compliance #: HL306318381C

Date Concluded: November 15, 2024

Name, Address, and County of Licensee Investigated:
Edgewood EGF Senior Living
608 5th Avenue NW
East Grand Forks, MN 56721
Polk County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Inconclusive

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 alleged perpetrators (AP), unlicensed personnel (ULP) at the facility, emotionally abused the resident when they treated him in a harassing and humiliating manner. Camera footage showed AP1 and AP2 being chased down the hallway by the resident and the two APs closed themselves behind a door. AP1 and AP2 could be seen watching a recording of the incident on AP1's phone and laughing.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. While AP1 and AP2 may have treated the resident in a discourteous manner, there was insufficient evidence to demonstrate abuse occurred. Conflicting reports were provided, and the facility did not retain camera footage of the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed the resident’s room.

The resident resided in an assisted living memory care unit. The resident’s diagnoses included cognitive decline and Parkinson's disease. The resident’s service plan included assistance with all activities of daily living and behavior management services. The resident’s assessment indicated the resident had dementia, memory loss, and cognitive impairment. The resident was at risk for aggression both to and from others during periods of high stress. The resident had a history of being physically aggressive, hallucinating, breaking property, hitting, slapping, and kicking his wife and staff, and become verbally aggressive. No interventions besides redirecting the resident were identified.

The facility’s internal investigation indicated management was notified of an incident that occurred on an overnight shift where two unlicensed personnel, alleged perpetrator (AP1) and AP2 were laughing at the resident. The incident report indicated the resident was agitated, throwing objects, and chasing staff. Surveillance camera footage was reviewed. It appeared that staff were repeatedly antagonizing the resident and running away from him. At one point, he chased them down the hallway and they closed themselves behind the magnetic door. The camera in the hallway showed that they were laughing and viewing something on AP1’s phone.

AP1 was interviewed by facility staff and reported she and AP2 entered the resident's room to help the resident’s wife when the resident became upset, began throwing objects and chasing them. AP1 denied intentionally aggravating the resident and stated she wanted to record the incident because the surveillance cameras don't always record everything.

AP2 was interviewed by facility staff and stated AP1 mocked the resident which angered him, and he attempted to hit her with an object. AP1 and AP2 left the room and returned when they heard the resident’s wife screaming. The resident did not want AP1 or AP2 back in the room and became upset again. AP2 reported that AP1 taunted the resident, and he threw a hairbrush and a plastic bowling pin at them before chasing them down the hallway. AP2 acknowledged AP1 recorded the incident on her phone, taunting the resident and using profanity. AP2 denied recording or possessing any recording of the incident. AP2 acknowledged that they were laughing during the incident and laughed when reviewing AP1’s recording of the incident.

Facility staff interviewed the resident who recounted two girls were taunting him and that one gave him the finger and they were laughing. He stated he chased them down the hallway and shut the door so they couldn't come back.

The resident was interviewed by the investigator, but he was unable to recall any details from the incident.

During an interview, AP1 stated they were not trying to play around but they ended up laughing because they didn't know why the resident was throwing things at them. AP1 stated she was trying to help the resident's wife when he became upset with them and was throwing items like a hairbrush and a bowling pin. AP1 denied recording the incident and stated that AP2 recorded a video, texted it to her and asked her to delete the video after AP2 was fired. AP1 stated she did have her phone out during the incident because AP2 told her to but she did not record anything. AP1 stated she took accountability for her actions that night and acknowledged laughing at the resident was not appropriate. AP1 stated they had not been trained on any interventions for dealing with the resident's behaviors so they were doing the best they could in a difficult situation.

During an interview, AP2 stated the resident got very angry after they tried to help his wife and he chased her and AP1 down the hallway with a hairbrush and a bowling pin. AP2 stated they tried to run away from the resident and AP1 was trying to mimic the resident and was repeating things he said. AP2 stated she did not have her phone out and denied recording anything. AP2 stated AP1 showed her AP1's phone and that she had recorded the incident. AP2 stated they were laughing at the resident because they didn't know what else to do. AP2 stated she had not been trained on any interventions for dealing with the resident's behaviors.

During an interview, facility management stated it seemed like AP1 and AP2 were intentionally antagonizing the resident and when they watched the surveillance footage, they could see them going in the room and coming back out a few times. Management stated that it was difficult to hear anything on the video, but the resident could be seen coming further and further out of his room until he chased the two staff members down the hallway. Facility management confirmed surveillance footage of the incident was not saved and not available for review.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes, AP1 and AP2

Action taken by facility:
The facility investigated the incident and filed a MAARC report. AP1 was terminated. AP2 was placed on administrative leave and later terminated.

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

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
	30631	A. BUILDING: _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD EGF SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

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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: #HL306315881M/ #HL306318381C On November 1, 2024, 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 XX residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL306315881M/ #HL306318381C, tag identification 0630, 1290, 2350.	0 000		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the	0 630		

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0 630	Continued From page 1 person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a individual abuse prevention plan (IAPP) with specific interventions for each known vulnerability for one of one resident (R1) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included age related cognitive decline and Parkinson's disease. R1's service plan dated March 22, 2024, indicated the resident received assistance with all activities of daily living and behavior management services. R1's assessment dated September 26, 2024, indicated the resident had dementia, memory loss, and cognitive impairment. The resident was	0 630		

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0 630	Continued From page 2 at risk for aggression both to and from others during period of high stress. Staff were to "proactively monitor and advocate for their residents. All concerns must be brought to the attention of the supervisor immediately. Staff are to adhere to established behavioral care plan interventions for all residents..." The resident had a history of being physically aggressive, hallucinating, breaking property, hitting, slapping and kicking his wife and staff, and become verbally aggressive. No interventions besides redirecting the resident were identified. Facility records included an internal investigation after allegations of verbal abuse were made against two unlicensed personnel/alleged perpetrators, AP1 and AP2. The incident on the overnight shift of August 7 to August 8, 2024 indicated "It was reported that during the incident, [R1] was agitated, throwing objects and chasing above staff. Surveillance camera footage was reviewed. It appeared that staff were repeatedly antagonizing [R1] and then running away from him. At one point, he did chase them down the east E pod hallway and they closed themselves behind the magnetic door. The camera in the hallway showed that they were laughing and viewing something on [AP1] phone. After viewing footage of the incident, this writer placed a call to [licensed assisted living director] who is currently out of the building. [Regional vice president] contacted this writer as it was brought to her attention that [AP1] had recorded a resident and taken footage of an incident on her phone, which is a HIPPA (sic) violation. Discussion was held and decision was made to issue termination to [AP1] and place [AP2] on administrative leave until we can further investigate the situation." Facility management updated R1's son and interviewed the resident and the APs.	0 630		

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0 630	Continued From page 3 On November 5, 2024, at 11:30 a.m., AP1 stated they were not trying to play around but they ended up laughing because they didn't know why he was throwing things at them. AP1 stated she was trying to help the resident's wife and R1 became upset with them and was throwing items like a hairbrush and a bowling pin. AP1 stated she took accountability for her actions that night and acknowledged laughing at the resident was not appropriate. AP1 stated they had not been trained on any interventions for dealing with the resident's behaviors so they were doing the best they could in a difficult situation. On November 5, 2024, at 12:15 p.m., AP2 stated R1 got very, very angry with them after they tried to help his wife and he chased her and AP1 down the hallway with a hairbrush and a bowling pin. AP2 stated they tried to run away from the resident and AP1 was trying to mimic R1 and was repeating things he said. AP2 stated they had been laughing at the resident because they didn't know what else to do. AP2 stated she had not been trained on any interventions for dealing with the resident's behaviors. On November 6, 2024, at 10:10 a.m.,registered nurse (RN)-D confirmed R1's assessment lacked individualized interventions for responding to the resident's behaviors. RN-D stated she knew the resident would get irritated with loud noises and they would have to have him sit at a specific spot for meals so he wouldn't get irritated. RN-D stated the resident loved to talk about farming, his grandchildren, sports, and liked to read the bible every day and that telling him you had spoken with his son would help calm the resident down. RN-D confirmed none of that information on interventions were incorporated into the resident's	0 630		

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0 630	Continued From page 4 IAPP. The licensee's undated Individual Abuse Prevention Plan policy indicated the individual abuse prevention plan would contain an individualized assessment of the resident's susceptibility to be abused by other individuals, including other vulnerable adults, the resident's risk of abusing other vulnerable adults, the resident's risk of abusing self, and statements of the specific measures to be taken to minimize the risk of abuse to the resident and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 630		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

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01290	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current employee records contained all the required content to include a current background study clearance letter for two of two employees alleged perpetrator (AP1) and AP2, both unlicensed personnel (ULP). This had the potential to affect all residents living within the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: AP1 AP1 was hired on May 24, 2024, to provide direct care and services to the licensee's residents. AP1 was terminated on August 8, 2024, after she was accused of being involved in an incident of abuse of a resident. AP1's record contained a background screening report from an independent agency dated May 22, 2024, and a Final Registry Results Form from NETStudy 2.0 dated May 31, 2024. AP1's record lacked a background study clearance letter. On November 1, 2024, NETStudy 2.0 was reviewed and indicated AP1 was affiliated with the licensee's roster on May 31, 2024, and removed	01290		

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01290	Continued From page 6 on August 9, 2024. AP2 AP2 was hired on May 9, 2024, to provide direct care and services to the licensee's residents. AP2's record contained a background screening report from an independent agency dated April 30, 2024, and a Final Registry Results Form from NETStudy 2.0 dated May 31, 2024. AP2's record lacked a background study clearance letter. AP2 was terminated on August 8, 2024, after she was accused of being involved in an incident of abuse of a resident. AP2's record contained a Supervision of Unlicensed Personnel evaluation that was to be completed within 30 days for new employees performing delegated tasks. The evaluation was completed on June 1, 2024. Facility schedules indicated AP2 was allowed to work as a ULP through her termination despite not having a current background study clearance letter. On November 1, 2024, NETStudy 2.0 was reviewed and indicated AP2 was affiliated with the licensee's roster on May 31, 2024, but removed from the roster on June 15, 2024. Supervision was required for AP2. No results for AP2's background study were posted. On November 5, 2024, a DHS representative confirmed a background study for AP2 was not completed as the employee did not fill out a disclosure form within 14 days so the study was closed and a criminal background study was	01290		

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01290	Continued From page 7 never initiated on AP2. The DHS representative stated the registry check completed by the licensee was not a criminal background check and would not substitute for a clearance letter. On November 5, 2024, at 12:15 p.m., AP2 stated she began working independently as a ULP before she went in to get her fingerprints taken as she had been called by a facility scheduler who asked her to come in for orientation so she assumed it was ok. AP2 stated she did not realize a background study was never done for her and did not recall seeing any notices alerting her that the study was incomplete and would close. AP2 confirmed she was not directly supervised while providing direct care to residents. Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. The licensee's Minnesota Background Requirements policy dated February 2024, indicated a new hire could begin working before a background study and finger print results were in if the facility received a cleared background study from Veritable Screening and have initiated the NetStudy 2.0 background study. The policy indicated a new hire may begin working as long as they did not have unsupervised resident	01290		

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01290	Continued From page 8 contact. The policy did not address background study clearance letters. No further information was provided. TIME PERIOD OF CORRECTION: Two (2) days	01290		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure one of one resident (R1) was treated with courtesy and respect when two facility staff members were observed laughing at the resident after he chased them down a hallway and recording the incident on a phone. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1's diagnoses included age related cognitive decline and Parkinson's disease. R1's service plan dated March 22, 2024, indicated the resident received assistance with all	02350		

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02350	Continued From page 9 activities of daily living and behavior management services. R1's assessment dated September 26, 2024, indicated the resident had dementia, memory loss, and cognitive impairment. The resident was at risk for aggression both to and from others during period of high stress. Staff were to "proactively monitor and advocate for their residents. All concerns must be brought to the attention of the supervisor immediately. Staff are to adhere to established behavioral care plan interventions for all residents..." The resident had a history of being physically aggressive, hallucinating, breaking property, hitting, slapping and kicking his wife and staff, and become verbally aggressive. No interventions besides redirecting the resident were identified. The licensee's internal investigation indicated management was notified of an incident that occurred on the overnight shift of August 7th/August 8th, 2024. "It was reported that during the incident, [R1] was agitated, throwing objects and chasing above staff. Surveillance camera footage was reviewed. It appeared that staff were repeatedly antagonizing [R1] and then running away from him. At one point, he did chase them down the east E pod hallway and they closed themselves behind the magnetic door. The camera in the hallway showed that they were laughing and viewing something on [AP1] phone. After viewing footage of the incident, this writer placed a call to [licensed assisted living director] who is currently out of the building. [Regional vice president] contacted this writer as it was brought to her attention that [AP1] had recorded a resident and taken footage of an incident on her phone, which is a HIPPA (sic) violation. Discussion was held and decision was made to	02350		

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02350	Continued From page 10 issue termination to [AP1] and place [AP2] on administrative leave until we can further investigate the situation." Facility management updated R1's son and interviewed the resident and the APs. AP1 was interviewed by facility staff on August 8, 2024. AP1 reported she and AP2 entered the resident's room to help his wife and the resident became upset with them and he began throwing objects and chasing them. "When asked if she had been intentionally aggravating [R1] and making obscene gestures as it appeared in our surveillance, she denied doing so. When confronted with the fact she had been recording the incident and laughing at the video with her coworker in the hallway behind a door while the resident was upset on the other side of the door, she stated she wanted to record it because our surveillance cameras don't always record everything. Writer informed her that her behavior did not follow Edgewood procedure for dealing with an upset resident, that intentionally returning and antagonizing a resident could be construed as mental abuse and that videoing a resident in such a manner is a HIPPA (sic) violation. She was notified at that time that her employment with Edgewood would be terminated." The internal investigation indicated the resident was interviewed on August 8, 2024, at 5:30 p.m. and the resident "recounted that there were two girls who were taunting him and that one gave him the finger and that they were laughing. He stated that he did chase them down the hallway and had then shut the door so they couldn't come back..." AP2 was interviewed by facility staff on August 9, 2024. AP2 reported she and AP1 entered R1's	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02350	Continued From page 11 room to help the resident's wife and the resident was agitated and yelling at them to get out of the room. AP2 stated AP1 mocked R1 and further angered him and he attempted to hit her with an object. AP2 stated they left the room and she went outside and when she returned she heard R1's wife screaming so she and AP1 returned to the room. R1 did not want them back in the room and became upset again. AP2 reported that "AP1 taunted [R1] then ran away, then went back to him again and ran back at which time he threw a hair brush and a plastic bowling pin at them. She then went back to him again and ran when he started chasing them down the east E pod hallway where they stopped once they were behind the hallway door by the time clock. She acknowledges that [AP1] was recording the incident on her phone, taunting [R1] and using profanity. [AP2] denies having made any recording or possessing any recording. She acknowledges that they were laughing during the incident and that [AP1] had played back the video she and that they were laughing at it while standing by the time clock..." On November 1, 2024, at 12:25 p.m., R1 was interviewed about the incident. R1 could not recall any details from the event. On November 5, 2024, at 11:30 a.m., AP1 stated they were not trying to play around but they ended up laughing because they didn't know why he was throwing things at them. AP1 stated she was trying to help the resident's wife and R1 became upset with them and was throwing items like a hairbrush and a bowling pin. AP1 denied recording the incident and stated that AP2 had recorded a video and texted it to her and later asked her to delete the video after AP2 was fired. AP1 stated she did have her phone out during the	02350		

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02350	Continued From page 12 incident because AP2 had told her to but she did not record anything. AP1 stated she took accountability for her actions that night and acknowledged laughing at the resident was not appropriate. AP1 stated they had not been trained on any interventions for dealing with the resident's behaviors so they were doing the best they could in a difficult situation. On November 5, 2024, at 12:15 p.m., AP2 stated R1 got very, very angry with them after they tried to help his wife and he chased her and AP1 down the hallway with a hairbrush and a bowling pin. AP2 stated they tried to run away from the resident and AP1 was trying to mimic R1 and was repeating things he said. AP2 stated she did not have her phone out and denied recording anything. AP2 stated AP1 showed her AP1's phone and that she had recorded the incident. AP2 stated they had been laughing at the resident because they didn't know what else to do. AP2 stated she had not been trained on any interventions for dealing with the resident's behaviors. On November 5, 2024, at 2:10 p.m., clinical nurse supervisor (CNS)-C stated it seemed like AP1 and AP2 were intentionally antagonizing the resident and when he watched the surveillance footage, he could see them going in the room and coming back out a few times and it was kind of difficult to hear anything on the video but the resident could be seen coming further and further out of his room until he chased the two staff members down the hallway. CNS-C confirmed surveillance footage of the incident was not saved. No further information was provided.	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02350	Continued From page 13 TIME PERIOD FOR CORRECTION: Seven (7) days	02350		