

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL324577404M  
**Compliance #:** HL324573964C

**Date Concluded:** December 19, 2023

## **Name, Address, and County of Licensee**

### **Investigated:**

Edgemont Place Alzheimer's Specialty Care  
11748 Ulysses Lane Northeast  
Blaine, MN 55435  
Anoka County

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

**Evaluator's Name:** Holly German, 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 a resident when multiple, various skin injuries were found during an assessment.

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was not substantiated. The facility communicated changes with the provider and provided medical care as ordered.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident's internal and external medical records, provider notes, staff schedules, facility policies and a law enforcement report. Also, the investigator completed an onsite visit and observed staff assisting the resident with cares.

The resident resided in an assisted living memory care unit. The resident's diagnoses included cognitive impairment and arthritis. The resident's service plan included assistance with dressing, bathing, medication administration and mobility. The resident's assessment indicated she was alert to only herself, used a wheelchair with assistance, and was at risk for falls. The resident took a blood thinner medication (Coumadin) daily.

After one month of residing at the facility, an incident report indicated staff found the resident to be on the floor in her bedroom during the overnight shift. Staff assisted her back to bed and noted abrasion, bruising, and swelling injuries to the resident's face. Staff updated the medical provider and family. The resident went to the emergency room for evaluation.

Hospital records indicated hospital staff noted multiple various skin injuries. The emergency room physician did not state a diagnosis for the skin injuries. The resident returned to the facility with treatment orders in place.

The facility nurses' notes indicated the resident's left arm was noted to be more swollen than the right with intact blisters present. When rechecked later in the shift, staff reported to the nurse some of the blisters had opened while others remained intact. The nurse indicated there were no signs or symptoms of infection, staff were to continue to monitor and report any changes. The same document indicated two days later, a family member brought the resident to a second nurse and showed the nurse the resident's left arm which had a row of blisters present with some of which were open. The nurse updated the provider at that time and received treatment orders the following day. The nurses' notes indicated the blisters had dried and redness resolved five days later. Three days after they resolved, the notes indicated staff noted the resident's left arm was swollen and tender. The resident was unable to feed herself as a result. Staff sent the resident to the emergency room for evaluation and returned to the facility the following day with treatment orders.

Hospital records indicated the medical provider provide no diagnosis during her evaluation in the emergency room. The provider ruled out cellulitis (skin infection), shingles, septic joint, and sepsis (blood infection). The medical provider discussed hospital admission with the resident's family member due to the family members concerns about the facility. The family member declined hospital admission and the resident returned to the facility with orders for treatment.

After returning from the hospital, the resident's primary medical provider notes indicated the provider ordered steroid and antibiotic medications for the diagnosis of Bullous Pemphigoid (a skin condition caused by an autoimmune response at the epidermal level of skin).

During an interview, the registered nurse stated when staff find a skin concern, nursing instructed staff to assume they are the first to see it and report it right away. She stated a nurse completed resident skin checks on Mondays, and unlicensed staff also check residents' skin on their bath days.

During an interview, an unlicensed personnel stated if she found a skin concern on a resident, she would report it right away and chart it.

During an interview, when asked if staff had ever treated her badly, the resident stated no. The resident denied any rough handling by staff. The resident stated she felt safe in the facility and denied any skin concerns.

During an interview, a family member stated she did not feel the resident was abused. The family member stated it made sense the blisters could have been from an autoimmune reaction.

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 provided medical care as ordered by the provider.

**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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32457</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/07/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>EDGEMONT PLACE ALZHEIMER'S SPE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>11748 ULYSSES LANE NE BLAINE, MN 55434</b>
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(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	<p><b>Initial Comments</b></p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b></p> <p><b>#HL324574867C/#HL324577925M, #HL324573964C/#HL324577404M.</b></p> <p>On December 7, 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 42 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for <b>#HL324573964C/#HL324577404M</b>, tag identification 0730 and 2310.</p> <p>No corrections orders are issued for <b>#HL324574867C/#HL324577925M.</b></p>	0 000	<p>Minnesota Department of Health is documenting the State 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.</p> <p><b>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.</b></p> <p><b>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</b></p> <p><b>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.</b></p>	
0 730 SS=D	<p><b>144G.43 Subd. 3 Contents of resident record</b></p> <p>Contents of a resident record include the</p>	0 730		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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0 730	<p>Continued From page 1</p> <p>following for each resident:</p> <p>(1) identifying information, including the resident's name, date of birth, address, and telephone number;</p> <p>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;</p> <p>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;</p> <p>(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;</p> <p>(5) the resident's advance directives, if any;</p> <p>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;</p> <p>(7) the facility's current and previous assessments and service plans;</p> <p>(8) all records of communications pertinent to the resident's services;</p> <p>(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;</p> <p>(10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;</p> <p>(11) documentation that services have been provided as identified in the service plan;</p> <p>(12) documentation that the resident has received and reviewed the assisted living bill of rights;</p> <p>(13) documentation of complaints received and any resolution;</p>	0 730		

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0 730	<p>Continued From page 2</p> <p>(14) a discharge summary, including service termination notice and related documentation, when applicable; and</p> <p>(15) other documentation required under this chapter and relevant to the resident's services or status.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed document wound care services were performed for one of two residents (R1) reviewed. R1 received dressing change orders after developing blisters.</p> <p>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).</p> <p>The findings include:</p> <p>R1's diagnosis included cognitive impairment and arthritis. R1's service plan dated October 24, 2023, indicated R1 received assistance with behavior management, bathing, toileting, dressing, grooming, transfers, and medication administration.</p> <p>A nursing note dated July 3, 2023, at 11:04 p.m. indicated staff noted R1's left arm was swollen with intact blisters present. The same note indicated when rechecked, some of the blisters had popped and some remained intact. The nurse documented staff were to keep monitoring</p>	0 730		

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0 730	<p>Continued From page 3</p> <p>and report any changes. The same note lacked documentation the provider was updated and action taken for open skin wounds.</p> <p>A nursing note dated July 6, 2023, at 4:45 p.m. indicated R1's family member presented R1 to a second nurse to show the nurse R1's left arm with a row of blisters present with unknown origin. The nurse contacted the provider.</p> <p>A nursing note dated July 7, 2023, at 12:25 p.m. indicated the provider ordered a treatment to cover open areas with gauze or kerlix and directed staff to continue to monitor.</p> <p>R1's medication administration record dated July 1, 2023 through July 31, 2023, lacked documentation of dressing changes from July 7, 2023 through July 16, 2023.</p> <p>During email correspondence on December 18, 2023, at 11:07 a.m., director of nursing (DON)-D stated R1 did not have a treatment administration record for July 2023.</p> <p>Licensee provided policy titled Reporting, Documenting and Reviewing Incidents Involving Residents, undated, indicated the registered nurse would document in the resident's chart details of any incident involving the resident, their assessment including the follow-up actions that were taken.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 730		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	<p>Continued From page 4</p> <p>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to notify the resident's physician for a change in status and direction for treatment for one of two residents (R1) reviewed. R1 developed blisters, that had begun opening but the licensee failed to inform R1's physician until three days later when a second nurse took action.</p> <p>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).</p> <p>The findings include:</p> <p>R1's diagnosis included cognitive impairment and arthritis. R1's service plan dated October 24, 2023, indicated R1 received assistance with behavior management, bathing, toileting, dressing, grooming, transfers, and medication administration.</p> <p>A nursing note dated July 3, 2023, at 11:04 p.m., indicated staff noted R1's left arm was swollen with intact blisters present. The same note indicated when rechecked, some of the blisters had popped and some remained intact. The</p>	02310		

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02310	<p>Continued From page 5</p> <p>nurse documented staff were to keep monitoring and report any changes. The same note lacked documentation the provider was updated and action taken for open skin wounds.</p> <p>A nursing note dated July 6, 2023, at 4:45 p.m., indicated R1's family member (FM)-C presented R1 to a second nurse to show the nurse R1's left arm with a row of blisters present with unknown origin. The nurse contacted the provider.</p> <p>A nursing note dated July 7, 2023, at 12:25 p.m., indicated the provider ordered treatment to cover open areas with gauze or kerlix and directed staff to continue to monitor.</p> <p>During an interview on December 11, 2023, at 10:34 a.m., FM-C stated when she was visiting R1 in July, she noted blisters on R1's arm. FM-C brought R1 to the nurse who told her she would look in to it. FM-C stated she was notified the following day that a caregiver had noticed blisters on R1's arm three days prior. FM-C stated they should have notified her three days prior. FM-C stated the facility did not treat R1's skin issues until she brought it to their attention.</p> <p>During an interview on December 11, 2023, at 1:30 p.m., director of nursing (DON)-D stated the licensee had recently switched management and she had started employment after the incident with R1's blisters.</p> <p>Licensee provided policy "Initial and On-Going Nursing Assessment of Residents" dated July 25, 2023 indicates a RN will complete assessments as indicated by individual resident circumstances and skin conditions. The same policy stated the RN will reassess the resident if the resident has a change in condition and would communicate any</p>	02310		

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02310	Continued From page 6  new problems or concerns to the resident's physician.  TIME PERIOD FOR CORRECTION: Seven (7) days	02310		