Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL324577925M
Compliance #: HL324574867C

Date Concluded: December 15, 2023

Name, Address, and County of Licensee Investigated:
Edgemont Place Alzheimer's Specialty Care
11748 Ulysses Lane Northeast
Blaine, MN 55434
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 alleged perpetrator (AP) abused a resident when she hit the resident on the head.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The AP denied the allegation and passed a polygraph (lie detector) examination administered by law enforcement. The case was closed with no charges.

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 medical record, staff schedules, personnel files, the facility's investigation report and law enforcement report. Also, the investigator conducted an onsite visit to the facility and observed staff performing care assistance with the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease and osteoarthritis. The resident's service plan included assistance with behavior management, toileting, dressing, bathing, and medication administration. The resident's assessment indicated use of a wheelchair and memory loss.

On the date of the incident, an unlicensed personnel (ULP) reported hearing screaming coming from the resident's room. Upon entering the room, the ULP stated she saw the AP hit the resident with an open hand on the right side of her head. The ULP left the room and notified another staff member who went to the resident's room and directed the AP to leave the resident's room.

The facility incident report indicated administrative staff assessed the resident as soon as she entered the facility once notified of the incident by phone. The administrative staff did not note any bruising or marks on the resident's skin. The following morning, the resident remained free of any skin markings.

A law enforcement report indicated law enforcement spoke with the AP. The AP denied hitting the resident and stated she wanted to take a polygraph test. The report indicated the AP was being truthful and did not harm or injure the resident. Law enforcement updated the resident's son with the case information. The report indicated the case was closed.

During an interview, the AP denied abusing the resident. The AP stated the evening of the alleged incident, the resident needed her brief changed before going to bed, and the resident was being resistive to toileting assistance. The AP stated she attempted to convince the resident more than six times without success, so she requested assist from another staff member to help. The AP stated the resident was hitting and scratching her while she and the other staff member attempted to change the resident and clean her skin. The AP stated she witnessed the ULP leave the room but was not aware that she had re-entered the room. The AP stated she heard the ULP stating she was calling management, and she did not understand why. The AP stated the police contacted her a few days later and she was interviewed by them. The AP requested a polygraph test, which law enforcement staff administered. The AP stated she passed the test, and she was cleared of everything. The AP stated she felt the ULP made up the abuse claim because she did not like her and had a conspiracy against her.

During an interview, the resident stated she felt safe at the facility. The resident denied staff treating her badly. The resident did not recall staff ever forcing her to do something she did not want to do.

During an interview, the nurse stated all staff receive abuse and neglect training upon hire. The nurse stated the resident does have memory loss and can have simple conversation making her needs known. The nurse stated she was notified of the allegation the next morning. The nurse started an investigation and spoke with the resident who kept referring to somebody hitting her repeatedly.

During an interview, a family member stated the resident has dementia, and her long-term memory was better than her short-term memory. The family member stated he visited the resident the following day of the alleged incident and did not see any cuts or bruises. He asked the resident if the staff were treating her well; she stated yes, and that she liked it at the facility. The family member stated he did not know if the resident was hit or not, but the resident did not remember it if it did happen. The family member stated he did not pursue criminal charges on the staff member because she passed the polygraph test, and he was not sure if it happened or not. The family member stated he felt the resident was safe at the facility.

In conclusion, the Minnesota Department of Health determined abuse 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.

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;
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;

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility reported to the Minnesota Adult Abuse Reporting Center.

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
	32457	A. BUILDING: _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEMONT PLACE ALZHEIMER'S SPE	11748 ULYSSES LANE NE BLAINE, MN 55434

(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 ******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: #HL324574867C/#HL324577925M, #HL324573964C/#HL324577404M. 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. The following correction order is issued for #HL324573964C/#HL324577404M, tag identification 0730 and 2310. No corrections orders are issued for #HL324574867C/#HL324577925M.	0 000	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. 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.	
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the	0 730		

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0 730	Continued From page 1 following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (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; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (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; (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; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution;	0 730		

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0 730	Continued From page 2 (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. 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. 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 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. 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	0 730		

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0 730	Continued From page 3 and report any changes. The same note lacked documentation the provider was updated and action taken for open skin wounds. 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. 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. 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. 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. Licensee provided policy titled Reporting, Documenting and Reviewing Incidens 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. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 4 (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. 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. 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 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. 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	02310		

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02310	Continued From page 5 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. 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. 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. 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. 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. 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	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		