Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL265854201M
Compliance #: HL265854900C

Date Concluded: August 25, 2024

Name, Address, and County of Licensee Investigated:
Edgewood Assisted Living
673 Brianna Drive
Sartell, MN 56377
Stearns County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Substantiated, individual responsibility

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 the resident when she moved the chair with the resident in it to another table without her consent. The resident then threw lemonade on her, and in response, the AP threw water at the resident. The resident was upset, and AP just walked away, leaving the resident wet.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP threw the water at the resident and walked away, leaving the resident wet and upset.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigation included review of the resident's records, internal investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include major neurocognitive disorder. The resident's service plan indicated the resident was able to do most of activities daily living and needed supervision redirection and cuing. She required assistance with meals, medication management, and nursing oversight.

An incident report indicated the AP stated the resident refused to move to another table, so the AP moved the resident's chair, with her in it, to another table. The resident got upset and tossed her lemonade at the AP. Then the AP took water and threw it on the resident. The AP also said she told the resident that if she wanted to get "hot" next time, they could get "hot". The AP then walked away, leaving the resident wet. The same document indicated the resident was not able to say what happened.

During an interview, unlicensed caregiver #1 stated she worked on the evening the incident happened and witnessed the whole event. She said the AP moved the resident, who was sitting in a chair, to another table. The resident got upset and threw lemonade at the AP. The AP then grabbed water and threw it on the resident. The AP also said she was not afraid to throw hot liquids on the resident. Unlicensed caregiver #1 stated that the AP left, leaving the resident wet. The resident became very agitated with everyone after the incident. Unlicensed caregiver #1 then notified the nurse on call about what happened.

During an interview, unlicensed caregiver #2 stated she witnessed the whole event. She said the resident got upset and threw lemonade at the AP. The AP grabbed water and threw it at the resident. The AP then left the resident wet in the chair. Unlicensed caregiver #2 stated she stepped in to assist the resident and notified the nurse on call.

During an interview, a manager stated she heard from the nurse on call about what happened. The manager stated the AP was escorted out of the building immediately after the incident. The nurse on call interviewed the staff members working that night, as well as the AP. The AP was terminated after the internal investigation.

During the investigation, the investigator was unable to reach the AP and the family members after multiple attempts.

In conclusion, the Minnesota Department of Health determined abuse 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.

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: No, unable to interview related to dementia.
Family/Responsible Party interviewed: No, attempted but did not reach.
Alleged Perpetrator interviewed: No, attempted but did not reach.

Action taken by facility:
The facility escorted AP out of the building to keep the resident safe. They started the internal investigation and reported the event to the Minnesota Adult Abuse Reporting Center. The AP's employment was terminated.

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.
Stearns County Attorney
Sartell City Attorney

Sartell Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26585	A. BUILDING: _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD SARTELL LLC	677 BRIANNA DRIVE SARTELL, MN 56377

(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 August 1, 2024, the Minnesota Department of Health initiated an investigation of complaint HL265854201M/HL265854900C. The following correction order is issued, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment 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: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual AP was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	See Public Report for details.	