Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL265858204M
Compliance #: HL265855367C

Date Concluded: March 4, 2024

Name, Address, and County of Licensee Investigated:
Edgewood Sartell LLC
677 Brianna Drive
Sartell, MN, 56377
Sterns County

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

Evaluator's Name: Angela Vatalaro, 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), a staff member, neglected the resident when the AP did not follow the resident's plan of care and provide every 30-minute safety checks on the resident. The resident was found lying on the floor, surrounded in blood, without a pulse, and not breathing. The resident passed away.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The resident was at risk for falls and required every 30-minute safety checks. The AP failed to check on the resident for 2 ½ hours. The resident fell, sustained a head laceration (deep cut or tear of the skin), and was found deceased.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, hospice staff, and the AP. The investigation included review of

the resident medical records, incident reports, internal investigation, hospice records, the law enforcement report, the resident's death record, the AP's personnel file, and facility policy and procedures. Also, the investigator observed the resident's memory care unit and safety check documentation process.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease and heart failure. The resident's service plan included assistance with dressing, toileting, transfers, and stand by assistance with a walker for ambulation. The resident was disoriented daily and at high risk for falls. Staff were directed to anticipate the resident's needs and complete every 30-minute safety checks. The resident was on hospice services.

The facility incident report indicated at approximately 4:30 a.m. to 4:45 a.m. the AP found the resident lying on her back on the bedroom floor. The AP stated when he completed the resident's safety check at 2:00 a.m., the resident was sitting in her recliner with the lights and television on. When the AP found the resident on the floor, he called two other unlicensed staff to assist with the resident.

The resident's record indicated staff contacted the on-call nurse about the resident being found on the floor, unresponsive, without a pulse, and surrounded by "a lot of blood." Hospice services was contacted. Hospice services arrived, contacted the coroner, and received instruction from the coroner to contact law enforcement. Law enforcement and emergency medical services arrived at the facility. The resident's family requested an autopsy.

During an interview, the hospice nurse said when she arrived and went to the resident's room, it looked like the resident got up, tried to walk on her own, and hit her head on the corner of the nightstand. There was blood on the bedsheets as if the resident had turned herself and tried to crawl on the floor next to the bed. The hospice nurse stated due to the trauma of the resident's fall and subsequent death, the coroner told the nurse to call law enforcement.

The law enforcement report indicated the resident was found without a pulse and cold to the touch. The resident had what appeared to be a large laceration on her head directly above her left eye with swelling and bruising. The size of the laceration was difficult to see due to the amount of blood. There was a large amount of blood on the resident's head, nightgown, and the carpet under the resident's head. In addition, there was blood spatter on the resident's nightstand, wheelchair, and bed sheets. When law enforcement spoke to the AP, the AP said he discovered the resident around 4:30 a.m. on the floor with blood on the left side of the resident's face. The AP said he last checked on the resident around 2:00 a.m. when the resident was sitting in her recliner.

The medical examiner's report indicated a postmortem with radiographs (X ray) showed a laceration with associated bruising on the resident's left forehead. There was no underlying fracture or intracranial hemorrhage (bleeding within the skull). The resident's cause of death

was heart failure related to atherosclerotic cardiovascular disease (buildup of fats, cholesterol, and other substances in the artery walls).

During an interview, the AP stated he did not complete every 30-minute safety checks on the resident the day the resident fell and was found deceased. The AP stated when he arrived to shift, he conducted safety checks on all the residents on the unit. By 12:00 a.m., the AP completed his first round of checks. The resident was in her recliner watching television, lights were on, and she did not want to go to bed yet. The AP said he checked on the resident again between 2:00 a.m. and 2:30 a.m. The AP said there were no changes with the resident. The resident remained in the recliner watching television. The AP stated he did not hear any yelling out by the resident or any sounds from her room. When the AP checked the resident again around 4:30 a.m., the resident had fallen and was on the floor deceased. The AP contacted co-workers for assistance with the resident.

During an interview, leadership stated safety checks were an expectation for staff to perform in memory care. Frequency of safety checks was determined from the residents' assessment, and staff were instructed to document the safety checks in the resident's service record.

During an interview, a nurse stated prior to this incident staff documented completion of 30-minute safety checks once per shift and prior to the resident's fall, that documentation had been sufficient to ensure staff completed the resident's safety checks as care planned.

During an interview, another nurse stated the AP said he last checked on the resident at 2:00 a.m. The AP found the resident on the floor deceased at approximately 4:30 a.m. to 4:45 a.m. The nurse stated the AP did not complete every 30 minutes safety checks on the resident according to the resident's care plan. The nurse stated the resident had a history of self-transferring and not waiting for staff assistance. The nurse said when staff clicked on the service for a resident in the electronic record, the record provided staff instructions on how often to complete safety checks on a resident, and staff documented completion once per shift.

During an interview, a family member stated he received a call from the medical examiner's office informing him the resident died from a heart attack. The family member stated it could not be determined whether the resident had gotten up because she had a heart attack or had a heart attack and hit her head.

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. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Following the incident, the facility re-educated staff on safety checks and implemented a paper documenting system which included increments of time for documentation. The AP was no longer employed by 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
Sterns 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 11/28/2023

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 ******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: #HL265855367C/#HL265858204M #HL265857563C/#HL265859625M On November 28, 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 84 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL265853367C/#HL265858204M, tag identification 2360. No correction orders are issued for #HL265857563C/#HL265859625M.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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 two residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	