Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL265859625M
Compliance #: HL265857563C

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: 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 facility neglected the resident when the resident fell and sustained facial trauma, a nasal bone fracture, and a C5 spinous process fracture (neck spinal injury).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the facility failed to have a system in place where staff documented every 30 minutes safety checks, it could not be determined whether staff provided every 30-minute safety checks and if the safety checks would have prevented the resident's fall.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of the resident's medical records, incident reports, the resident's death records, 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 dementia. The resident's service plan included assistance with dressing, toileting, transferring, walked with a walker, and escorted to meals and activities. The resident was disoriented to place and time. The resident was at high risk for falls, attempted self-transfers, and required staff safety checks every 30-minutes. The resident was on hospice services.

The resident's incident report indicated one day at 3:45 a.m., the resident self-transferred out of her apartment, walked into the carpeted living room common area, lost her balance, and fell forward. Staff heard a noise and found the resident face forward flat on the ground. The resident sustained facial trauma and was bleeding from her glabella (skin between eyebrows and above nose.) Staff called the on-call nurse and arranged for the resident to be evaluated at a hospital.

The resident's scheduled services indicated the day the resident fell at 3:45 a.m., the resident received toileting services at 12:00 a.m., which was back dated, and time stamped by staff at 6:00 a.m. The record did not provide documentation for staff completing every 30-minutes safety checks.

The hospital record indicated the resident was diagnosed with a small subdural hemorrhage (brain bleed), nasal bone fracture, and C5 spinous process fracture. The resident had a complex nasal laceration (cut) and fracture that required surgery.

Four days later, the resident discharged back to the facility from the hospital on hospice services. The resident passed away the following day.

The resident's death record indicated the residents cause of death was closed head injury, and unwitnessed fall.

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 resident assessment, and staff documented completed safety checks in the resident's service record. Leadership stated staff documented the resident's safety checks one time an eight-hour shift. Leadership stated she had concerns facility staff were not completing safety checks as assessed and required.

During an interview, a nurse stated the resident fell, sustained a facial injury, and went to the hospital for evaluation. The resident had late-stage dementia and at times self-transferred and would not wait for staff assistance. The resident had a history of wandering. The nurse stated the resident was impulsive, got up and walked within the memory care's common areas, hallways, and wandered within the unit. The resident used a walker. The resident required every 30-minute safety checks. The nurse stated staff should document safety checks in the resident's service record. The nurse stated during an investigation of the resident's fall, staff documented the resident's every 30-minute safety checks. The nurse stated she had concerns

facility staff were not completing safety checks as required. No additional information was provided to establish staff completed every 30-minute safety checks on the resident.

During an interview, another nurse stated the resident fell face first, went to the hospital, returned to the facility, and passed away on hospice services. The nurse stated a safety check was when a staff member laid eyes on the resident to make sure they were safe and in the unit.

In conclusion, the Minnesota Department of Health determined neglect 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.

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: Not Applicable.

Action taken by facility:
After staff found the resident on the floor, staff called the on-call nurse, 911, and transferred the resident to the emergency room for evaluation.

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
	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		

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
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.	