Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304112242M
Compliance #: HL304113950C

Date Concluded: September 9, 2022

Name, Address, and County of Licensee Investigated:
Edgewood Brainerd Senior Living
14890 Beaver Dam Road
Brainerd, MN 56401
Crow Wing County

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

Evaluator's Name: Barbara Axness, RN
Jana Wegener, RN
Special Investigator

Finding: Not Substantiated

Nature of Visit:
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 abused residents when they inappropriately placed residents requiring an increased level of care on hospice. The allegation indicated residents were then chemically restrained and would die shortly after admission to hospice.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The facility appropriately admitted residents to hospice and provided medication administration services with no indication of use of chemical restraints. Some residents receiving hospice services in the facility had been on hospice for greater than six months. Medications prescribed to resident's that could have had the potential to sedate or restrain residents were not administered. No signs or symptoms of chemical restraint use were noted through observations made at the time of the onsite visit.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement. The investigation included review of facility policies, procedures, resident medical records, and observation of residents in the facility.

The investigator reviewed three residents (A, B, and C) who received hospice services, required extensive staff assistance, had a change in condition, and were prescribed controlled drugs that could cause sedation or chemical restraint.

Resident A was admitted to hospice almost four years ago with the qualifying diagnosis of Alzheimer's disease causing weight loss and increased dependence for activities of daily living (ADLs) with a life expectancy of six months.

Resident A was observed awake and alert, eating her meal, interacting with staff and other residents.

Resident A's record indicated she required assistance from staff with dressing, bathing, grooming, and utilized assistance of two staff with all transfers and incontinent care. Resident A received medication management services and was prescribed Haloperidol (an antipsychotic medication) every six hours as needed for agitation and anxiety, and Morphine (a narcotic medication) every four hours as needed for pain or shortness of breath. A review of Resident A's medication administration record indicated the resident had not received any doses of Haloperidol or Morphine in the last month.

Resident B was admitted to hospice 11 months ago with the qualifying diagnosis of degeneration of the brain causing increased dependance on staff for ADL's due to progressive weakness, decline in function despite therapies in the last six months, and declining cognitive function.

Resident B was observed in the dining room with their head down and appeared to be sleeping. The resident was responsive to light touch and verbal prompts from staff.

Resident B's after visit summary (AVS) indicated a psychiatric nurse practitioner reviewed the risks of using antipsychotic medications in elderly demented patients with the resident's family.

The note indicated resident B's benefits outweighed the risks, as the resident had significant paranoia and delusions causing discomfort and possible harm. The AVS indicated medications would be monitored and administered at the minimal effective dose.

Resident B's record indicated she received Gabapentin (an anticonvulsant medication) scheduled three times per day, Lexapro (an antidepressant medication) for depression and Seroquel (an antipsychotic medication) for neurocognitive disorder. Resident B's physician orders further included Morphine (a narcotic medication) to be administered every four hours as needed for shortness of breath or pain and Ativan (a benzodiazepine medication) every three hours as needed for agitation and anxiety. Resident B's medication administration record indicated no doses of Morphine or Ativan were administered in the last month.

Resident C was newly admitted to hospice in the last 30 days with the qualifying diagnoses of Alzheimer's disease secondary to acute respiratory failure, chronic obstructive pulmonary disease with acute exacerbation, heart failure, and stage 3 chronic kidney disease.

Resident C was observed to be awake and alert while being assisted with ADL's by two staff using a front wheeled walker.

Resident C's physician orders included Ativan (a benzodiazepine medication) to be administered every four hours as needed for anxiety or agitation, Haloperidol (an antipsychotic medication) every four hours for nausea and Morphine (a narcotic medication) every four hours as needed for shortness of breath or pain. A review of her medication administration record indicated the resident had not received any doses of these medications.

Resident C's AVS indicated a psychiatric nurse practitioner reviewed potential side effects of medications with the family and would continue to review and monitor medication changes.

When interviewed, Resident C stated she had no concerns and did not feel like she received too many medications. Resident C stated she felt supported by staff to continue to be as independent as she was able.

During investigative interviews, multiple staff members stated if any changes in a resident were noticed including sedation or decreased responsiveness, they would notify the RN and hospice nurse. Staff members stated before administering any as-needed (PRN) medication they would first try other non-pharmacological interventions.

During an investigative interview, a facility nurse stated a hospice referral may be sent for residents who have had a decline or change in condition who required additional services. The nurse stated their goal was to keep residents comfortable. The nurse stated if appropriate, the resident met qualifying criteria, and the family chooses to use hospice services, they would collaborate with hospice to meet the needs of the resident.

During an investigative interview, another facility nurse stated they worked closely with hospice and the psychiatric nurse practitioner to ensure the resident's pain and symptoms are monitored and managed.

When contacted, law enforcement stated they had not received any concerns of abuse using chemical restraints or criminal activity in the facility.

In conclusion, 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;
(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 Vulnerable Adult identified
Family/Responsible Party interviewed: No Family/Responsible Party identified
Alleged Perpetrator interviewed: No Alleged Perpetrator identified

Action taken by facility:
The facility worked in collaboration with hospice providers to communicate changes in condition. The facility provided education and training on hospice and end of life comfort cares to all staff. The facility worked with a nurse practitioner to ensure appropriate use of antipsychotic medications.

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
	30411	A. BUILDING: _____ B. WING _____	C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD BRAINERD SENIOR LIVIN	14890 BEAVER DAM ROAD BRAINERD, MN 56401

(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 Initial comments On August 24, 2022, the Minnesota Department of Health initiated an investigation of complaint HL304112242M/HL304113950C. No correction orders are issued.	0 000		