Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307381041M
Compliance #: HL307381130C

Date Concluded: September 28, 2022

Name, Address, and County of Licensee Investigated:
Edgewood Virginia I Senior Living
705 17th Street North
Virginia, MN 55792
St. Louis County

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

Evaluator's Name: Barbara Axness, 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:
The facility neglected the resident when staff failed to toilet the resident, resulting in the development of a pressure ulcer.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident's service plan indicated the resident was to be toileted or provided incontinent care six times per day. The resident had no documented pressure ulcers and facility staff, including licensed

nurses and unlicensed personnel, reported the resident had not had any pressure ulcers or skin breakdown and that he was toileted or provided incontinent care every four hours.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's skin assessments, progress notes, care plan, and assessments.

The resident resided in an assisted living facility. The resident's diagnoses included dementia, type two diabetes, and hypertension (high blood pressure). The resident's service plan included assistance with all activities of daily living (ADLs), toileting, and incontinence care. The resident's assessment indicated the resident had impaired functioning due to history of a traumatic brain injury and required staff assistance with mobility and toileting.

The resident's two most recent assessments indicated the resident's skin was intact and no pressure ulcers were present. The resident had daily progress notes documenting skin condition, with no pressure ulcers or skin breakdown noted.

The resident's service recap summary indicated the resident was toileted at or around the time the resident was care planned to be toileted.

During investigative interview, multiple unlicensed personnel (ULP) stated they did not recall the resident ever having pressure ulcers or skin breakdown. The ULPs stated the resident required assistance with toileting and would have to be checked and changed every few hours. The ULP stated the resident had his toileting times care planned and they would check on the resident based off the care plan.

During an interview, a nurse stated the resident did not have any pressure ulcers or skin breakdown. The nurse stated she did not believe the resident had ever had any skin breakdown. The nurse stated the resident was toileted or provided incontinent care six times per day per his service plan and staff would document when the resident was toileted. The nurse indicated the resident would occasionally refuse toileting but generally was toileted around the times care was scheduled.

During an interview with the resident's responsible party, the responsible party indicated she was at the facility every day and witnessed staff toileting the resident and providing cares. The responsible party indicated she was surprised to hear of the allegation, had no concerns and was happy with the care the resident received at the facility.

In conclusion, neglect 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, resident is deceased.
Family/Responsible Party interviewed: Yes, responsible party
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action required.

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
	30738	A. BUILDING: _____ B. WING _____	C 09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD VIRGINIA I SENIOR LIV	705 17TH STREET NORTH VIRGINIA, MN 55792

(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 September 13-14, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL307381041M/HL307381130C and #HL307381761M/HL307383387C. No correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care/Assisted Living License Providers. 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 surveyors ' 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 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3	