Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307381761M
Compliance #: HL307383387C

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(s):
Facility staff neglected the resident after failing to follow the resident's care plan for toileting, resulting in the resident developing repeated urinary tract infections.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident experienced frequent incontinence and was on a toileting schedule. The resident had a history of urinary tract infections (UTIs) and facility staff responded appropriately when the resident developed UTIs.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the physician. The investigation included review of the resident's care plan, service plan, incident reports, progress notes, hospital medical records, staffing schedules, and the facility's staffing plan.

The resident resided in an assisted living facility. The resident's diagnoses included neuroleptic Parkinson's, overactive bladder, and urinary urgency. The resident was noted to have a history of urinary tract infections. The resident's service plan included assistance with toileting. The resident's assessment indicated the resident was cognitively intact, had frequent incontinence and was to be toileted as scheduled every two hours while awake and as scheduled overnight. The resident was independent with ambulation with a four wheeled walker.

The resident's progress notes indicated the resident had two UTIs during the five-month time period reviewed. For the first UTI, the resident received antibiotic injections in the provider's office and the infection resolved. For the second UTI, which occurred three months after the first, a urine sample was ordered after a fall. The urine sample was collected three days after it was ordered, and treatment with an antibiotic started two days later. Progress notes indicated antibiotics were started late due to the original prescription order not being available at the pharmacy, resulting in the provider needing to send an order for a different antibiotic. After the completion of antibiotics, the resident was seen in the clinic and another urine sample was obtained. Progress notes indicated the UTI was "still bad with little improvement." The resident again received antibiotic injections at the provider's office and was prescribed on an oral antibiotic. Seven days later, no signs or symptoms of a UTI were present, and the UTI was considered resolved. Two days after this occurred, the resident had a fall. The resident was sent to the emergency room to check for a UTI and was found to still have an infection. The resident was again prescribed antibiotics for 14 days. Four days later, the resident was hospitalized for further treatment of the UTI.

The resident's hospital progress notes indicated the resident received intravenous (IV) antibiotics since the resident didn't respond or improve with the previous antibiotics. The provider noted the resident does not have urinary symptoms other than some worsening incontinence when she has a UTI. The hospital progress notes indicated the resident had a history of recurrent UTIs that would have different organisms and different antibiotic sensitivities. The resident was discharged back to the facility with an order for a long-term antibiotic.

During investigative interviews, multiple unlicensed personnel (ULP) stated the resident was frequently incontinent and as a result would routinely soak through her incontinent products. ULPs reported the resident had used a few different types of incontinent products but would still soak through her clothing at times. ULPs further reported they were aware of toileting times for the resident and would follow those times as best as possible. ULPs reported the resident would participate in various activities throughout the facility so they would always try

find her at activities to use the bathroom. ULPs stated the resident did get recurring UTIs and they would report any symptoms or concerns to the nurse.

During an interview, the facility nurse stated the resident was taken to the bathroom every two hours, but the resident also had incontinence and was prone to soaking through her incontinence product. The nurse stated the facility had been trying various products to prevent the urine soaking through on to her clothing. The nurse stated the resident had a long history of urinary tract infections and sometimes which were unresponsive to antibiotics. The nurse stated it could take a day or two to collect urine samples as the facility needed first needed to obtain an order and then collect the sample. The nurse stated in the past they had issues with collecting a sample due to things like the resident may have contaminated the sample with toilet paper, missed the collection hat, or was unable to produce a sample.

During an interview, another facility nurse stated the resident had a history of UTIs that were not always responsive to antibiotics. The facility nurse stated there was one instance where an antibiotic was not started right away due to the original prescription not being available at the pharmacy, so the provider had to order a different medication. The facility nurse stated sometimes there was a delay in obtaining a urine sample because they must first contact the doctor to get an order and then collecting the sample may take a day or two as the resident is incontinent. The facility nurse stated the resident is on a toileting plan but still experiences heavy incontinence. The facility nurse stated the resident can be toileted and be incontinent ten minutes later.

During an interview, the resident's provider stated it is common for the resident to have recurrent UTIs and had periods where she had multiple UTIs that are hard to treat. The provider stated the resident's UTIs were difficult to treat at times as antibiotics that should work are not effective and other treatment options need to be evaluated. The provider stated the resident has ongoing incontinence and has been under the care of a urologist.

The resident was interviewed and stated she felt staff assisted her to the bathroom often enough but stated she would still have accidents where she would soak through her incontinence products and have wet pants. The resident felt staff were responsive to requests for assistance and felt she was able to get help whenever she needed it.

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: Yes
Family/Responsible Party interviewed: Yes
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	