STATE LICENSING COMPLIANCE REPORT

Report #: HL307609488C

Date Concluded: October 30, 2024

Name, Address, and County of Facility Investigated:
Edgewood May Creek LLC
303 10th Street South
Walker, MN 56484
Cass County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30760	A. BUILDING: _____ B. WING _____	C 10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MAY CREEK LLC	303 10TH STREET SOUTH WALKER, MN 56484

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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: #HL307609488C On October 22, 2024, 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 47 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL307609488C, tag identification 2350.	0 000		
02350 SS=F	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by:	02350		

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02350	Continued From page 1 Based on interview and record review, the licensee failed to treat one of one (R1) resident with dignity and respect when the licensee threatened to terminate the resident's assisted living contract when she declined to accept additional services from the facility. This had the potential to affect all residents who declined additional services from the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The Findings include: R1 was admitted to the facility on June 1, 2021. R1's diagnoses include high blood pressure. R1's assessment dated September 16, 2024, indicated the resident did not have any recent weight gain or weight loss and her weight had been stable. However, documentation provided by the facility indicated the resident had experienced a recent significant weight loss. The assessment indicated resident had wound care from the facility and an outside home care provider, however the resident's wound had been resolved since at least May 2024. The assessment indicated the resident was independent with activities of daily living and managed her own medications. R1's service plan dated June 2, 2021, indicated the resident was on service package level one	02350		

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02350	Continued From page 2 and received dressing changes to a wound daily by unlicensed staff and supervision from the RN once per week. R1's record contained an unsigned service plan dated October 11, 2024, which indicated the resident was on service package level one but no services from that package level were identified on the service plan. A Leveling Tool document indicated the service the resident was receiving was a licensed nurse evaluation other than the initial evaluation. R1's progress notes contained the following entries: -October 16, 2024, LALD-A documented that the resident to "let me know that she was refusing the 90-day required nursing assessments on her service plan. I reviewed with her the information that was settled at the last care conference. We are licensed as assisted living with dementia care and we did not have independent living situations in our community. I did let her know that if she did not feel that she needed assisted living any more, there are other communities that are licensed for independent living. I further explained that those communities that have assisted and independent living have separate residency agreements for each of those situations. She again stated that she does not want nor need assisted living, she does, however, like that grab bars in the bathroom. I did say that those are assistive medical devices that can be installed in private and independent units. I also told her that when she first came to May Creek, she needed that assisted living help due to the wound care. If she no longer required assisted living, that is a good thing, that means that she is doing well. She brought up the cost of what she was paying for the assisted living Room and Board and Service	02350		

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02350	Continued From page 3 Plan. I responded that we were unsure of why she would want to pay to be in assisted living if she refused to be assisted by staff. She laughed. We had a pleasant conversation and she seemed to understand about the licensing. She also asked about the statement for October. I explained that we (myself, my boss, and accounting) had a meeting on teams to go over the statement. We did get it adjusted and it was mailed to her and to [her daughter and POA]. I further explained what the invoice should reflect and that the statement goes back to the beginning of May 2024 so that they are getting the full picture." -September 26, 2024, a care conference was held to discuss the resident refusing all services aside from nursing evaluations. The "resident has been informed (in detail) that Edgewood May Creek LLC and Edgewood Management Group will no longer be held liable for issues that develop due to refusal of those services listed above." -August 2, 2024, the resident's power of attorney (POA)-B "approached the ED's [executive director's] office with a demand for the services checklist for the month's in question. The ED explained that she has already been provided the service plan and explanation of services. The ED further explained that during the conversations with [the resident], she had agreed that the services provided were accurate and rewrote a check for the accurate statement amount of $7,169.84. [POA-B] stated that her mother had never agreed or authorized the increase in services. She further stated that the reason that she rewrote the check was because she felt badgered to do so. [POA-B] then corrected her statement to say that "she felt pushed". The ED	02350		

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02350	Continued From page 4 responded that given the light heartedness of the conversation, she had no reason to believe that [the resident] felt pressured in any way. [POA-B] again demanded the policies regarding Edgewood services and the services checklist. [POA-B] stated "I'm not waiting, I want it right now". The ED stated that she was in contact with the RND [regional nursing director] and the RVP [regional vice president] and the was a Pre-Term Care Conference scheduled. The ED also stated that they would not be having the discussion again regarding the authorization, MD [doctor's] orders, or the services checklist. Any and all items in question would be discussed at the scheduled Care Conference. [POA-B] then stated "So, you're going to do this, this is sad. You're going to do this to my mother. This is so sad". -August 1, 2024, POA-B left a note requesting a print out of services provided. "The ED saw the note and proceeded to print off a copy of the service plan for [the resident]. [POA-B] then appeared at the ED's office door. [POA-B] ask if the ED had gotten her note and if the service list was printed. When handed the service plan, [POA-B] stated that it was not what she was asking for. The ED asked her to come into the office to discuss what she was looking for. While trying to explain the changes that dictated the elevation of services and change in service level, [POA-B] repeated that it was never approved. The ED stated that she, the CSD [clinical services director], the BOD [business office director], and [the resident] sat down and went over the reason for the elevation in the service level. [The resident] agreed that it was valid and wrote a check to cover the charges for the elevation in service level. [The resident] had originally wrote a check for $5,525.00 as was her previous statement amount. The updated amount that she	02350		

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02350	Continued From page 5 wrote the new check out for was $7,169.84. The ED asked [POA-B] if she had any reason to believe that her mother would not understand the information that we were going over with her. [POA-B] stated that "My mother can understand, but there's no way that she would ever agree to that". The ED then went on to explain that if there was a question about whether or not [the resident] could understand the information, that would be a cause for concern and we would need to have a POA that could make those decisions on her behalf. The ED went on to say that she had witnessed no indication that she could not understand the information that was prevented in that meeting. [POA-B] again demanded a print out of the explanation of services. The ED responded by handing her the service plan and stated that she had a meeting and in the future we would need to schedule any further discussions. The ED did inform [POA-B] that she would be getting the schedule Term of Services Conference notification in the mail, and we could discuss possible solutions in that meeting." -July 31, 2024, "[POA-B] entered the doorway to the EDs office and demanded an explanation of service and statement amount. She stated that we were wrong about charging her mother for the services provided. The ED tried to explain the reason for the service increase that was required following a status change in her mother's condition. She stated that "it was never discussed with her mother and never authorized by her mother". The ED invited [POA-B] into the ED's office so that the door could be closed as resident services were being discussed. She refused and continued to stand in front of the ED's office door. The ED continued to try and explain that when she initiated a concern for her mother to the ED, CSD, and the RN manager, we started taking	02350		

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02350	Continued From page 6 weekly weights and monitoring her mother for possible depression. A conversation took place with [POA-B] on 06/21/2024 regarding her mother's weight. A doctor's appointment was set up for [the resident] and [POA-B] took her to that appointment. As a result of that appointment, we received an order to monitor [the resident's] weight every two weeks. [The resident] was changed from a service level 1 to a service level 2 until the doctor's order was discontinued. She was then moved back to a service level of 1. As the ED was trying to explain the sequence of events, she was silenced by [POA-B] repeating that we were not authorized to elevate her service level. She wanted to "see the law that aloud [sic] us to elevate her service level and who gave us the authority to charge her more". She demanded a print out of the law and a print out of the service plan for [the resident]. She was given a print out of the service plan and she has the EDs book of regulations for assisted living. -July 9, 2024, a nurse documented "This nurse spoke with [the resident] after receiving order to do biweekly weights instead of monthly from [doctor]. I explained to her that if she was agreeable to biweekly to keep an eye on weight as to not have her lose undo weight at age 85. This writer explained that this additional service would not change her service level. She was in agreement to biweekly weights." The resident's service plan was not updated to reflect the addition of services. R1's Resident Agreement dated August 1, 2021, indicated on page four, section seven, "If you require health or supportive services beyond those included in the monthly base fee, a written service plan will be established for you and attached to this agreement as Attachment D (the	02350		

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02350	Continued From page 7 "service plan") Your Service Plan, if you need one, will be developed based on your individual needs, preferences, and requests and will offer flexibility that supports lifestyle choices related to health, wellness, social, spiritual and leisure activities. The Service Plan, as revised from time to time remain consistent with periodic nursing assessments, is incorporated in and considered part of this Agreement. It is important that you understand that if your needs change over time while you reside at the Community such that you require additional health or supportive services from us, the amount you are required to pay each month will increase." Page eight, section 13 of the agreement indicated to be a resident at the community, the resident would need to be able to live within the terms of the agreement, either independently or with the assistance of supportive and/or health related services, the staffing level required for care could not compromise or require changes to the overall staffing level of the community, and the resident's conduct could not create a danger to the resident, other residents, visitors, volunteers or staff. Page 22, attachment E identified circumstances that may result in expedited termination. Reasons for expedited termination included elopement, inappropriate urine/defecation, needing a mechanical lift or two person transfer, unwillingness to accept assistance with ADLs and or care needs outlined in a service plan, frequent falls, or care needs which could not be safely delegated or managed by a registered nurse. Nowhere in the licensee's assisted living agreement did it disclose a base service package and a service plan were required as a condition of admission or ongoing residency at the facility.	02350		

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02350	Continued From page 8 The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated May 17, 2022, indicated the facility provided services to include assistance with activities of daily living, medication management, and other nursing services. The UDALSA did not indicate a base service package and a service plan were required as a condition of admission or ongoing residency at the facility. The licensee's Resident Handbook included information on various services and amenities and facility procedures. The Resident Handbook did not indicate a base service package and a service plan were required as a condition of admission or ongoing residency at the facility. On October 22, 2024, at 10:55 a.m., R1 stated after her wound healed, she didn't need services from the facility anymore as she preferred to manage her own medications and do her own ADLs. R1 stated the facility increased her service level one to a level two earlier this summer after they began taking more frequent weights and she didn't realize it would move her to another price level. R1 stated she had decided to stop all services as she didn't feel she should have to pay $850 for someone to tell her she needs to go to the doctor. R1 stated she had paid the increased fee and paid for services she had declined as she didn't want to get evicted as she liked living at the facility and being close to her children. R1 stated the situation was irritating because "you're just throwing 800 some dollars in the wind." R1 stated she was not made aware it was required every resident be on a service level one package to reside at the facility. On October 22, 2024, at 11:30 a.m., LALD-A	02350		

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02350	Continued From page 9 stated as of now, the facility had not offered independent living residents and they were not willing to alter or fundamentally change what they do to allow a resident without services to live at the facility. LALD-A acknowledged a resident who did not receive services would not be required under statute to have a quarterly assessment or service plan but the facility chose to require those things for all residents. LALD-A stated the facility had made some concessions by allowing the resident to retain her level one rate as it had gone up recently and the facility was not willing to make any more concessions because it would alter the nature of their operations. On October 23, 2024, at 10:50 a.m., POA-B stated they initially became frustrated when the facility began taking additional weights which moved the resident to a service level two package, which increased the resident's monthly cost. POA-B stated they had tried to understand why her service level went up and would get confusing or conflicting information and never got the full story. POA-B stated after the resident's wound resolved, they did not need services from the facility anymore and thought they'd be able to drop the service package. POA-B stated they were told during a care conference the resident would have to choose to receive at least one service from the list and they reluctantly agreed to 90 day nursing assessments. POA-B stated they were told the facility was required to provide at least one service under the regulations however she pointed out the contract did not say it was required. POA-B stated the facility had pushed that the resident needed to be on services or she would be kicked out as she could not live at the facility if she did not receive any nursing services. On October 28, 2024, LALD-A confirmed the	02350		

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02350	Continued From page 10 contract did not explicitly identify that a base service package was required as a condition of admission and ongoing residency. LALD-A stated the requirement was something that was discussed while on tours and as they're signing the resident agreement. LALD-A stated the legal team was looking at the language related to expedited termination in the agreement as they were aware some points were not allowed under the assisted living regulations. LALD-A stated the resident would have the right to refuse services but the facility would also not be required to fundamentally alter their operations to accommodate a resident's request and allowing an independent resident to reside at the facility would be requiring them to fundamentally alter their operations. LALD-A stated since the resident was not taking any services, she would no longer be appropriate to reside at the community like a resident who required a two person assist would also not be appropriate to reside at the facility. LALD-A confirmed if the resident continued to refuse to accept a base service level one package, they would move to terminate the resident's contract and schedule a pre termination meeting. LALD-A stated based on their understanding of the regulations, they reserve the right to require services and if someone doesn't need services they wouldn't move into the community because they're not ready for it yet. Minnesota Statute 144G.52 Subd 5 indicated expedited termination may be initiated if (1) the resident has engaged in conduct that substantially interferes with the resident's health or safety; (2) the resident's assessed needs exceed the scope of services agreed upon in the assisted living contract and are not included in the services the facility disclosed in the uniform	02350		

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02350	Continued From page 11 checklist; or (3) extraordinary circumstances exist, causing the facility to be unable to provide the resident with the services disclosed in the uniform checklist that are necessary to meet the resident's needs. The Minnesota Bill of Rights for Assisted Living indicated under section two that residents have the right to refuse care or assisted living services and to be informed by the facility of the medical, health-related, or psychological consequences of refusing care or services. Section three indicated residents have the right to actively participate in the planning, modification, and evaluation of their care and services. This right includes: the opportunity to discuss care, services, treatment, and alternatives with the appropriate caregivers; the right to include the resident's legal and designated representatives and persons of the resident's choosing; and the right to be told in advance of and take an active part in decisions regarding any recommended changes in the service plan. No further information was provided. Time period for correction: Seven (7) days.	02350		