Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL324574784M
Compliance #: HL324576303C

Date Concluded: September 30, 2024

Name, Address, and County of Licensee Investigated:
Edgemont Place Alzheimer's Specialty
11748 Ulysses Lane NE
Blaine, MN 55434
Anoka County

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

Evaluator's Name: Deb Schillinger RN BSN
Special Investigator

Finding: Not Substantiated

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 sufficient supervision was not provided in the dining room and the resident choked.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility acted appropriately and contacted emergency medical services (EMS) immediately upon the resident's change in condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record, death record, hospital records, facility internal investigation, facility incident reports, staff schedules, and related facility policy and

procedures. Also, the investigator made an onsite visit and observed facility staff members providing care to and interacting with current residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, high blood pressure and recurrent falls. The resident's service plan included assistance with meals, requiring a mechanical soft diet and nectar thick liquids. The resident's assessment indicated the resident had limited communication and needed assistance of one staff member for transfers and a wheelchair for mobility.

A facility report indicated the resident became agitated at mealtime requesting a dietary item not allowed on mechanical soft foods with nectar thickened liquids diet. Shortly thereafter, facility staff members noticed the resident's breathing pattern changed and, when a nurse asked him if he was okay, he did not respond verbally. The nurse initiated the Heimlich maneuver (a first aid technique used to help someone who is choking) and transferred the resident to the hospital via EMS.

Hospital records indicated the resident's heart stopped and cardiopulmonary resuscitation (CPR) was initiated in the ambulance enroute to the hospital. The same document indicated the resident was pronounced dead in the emergency room.

During an interview, the nurse stated the resident became agitated during the evening meal and was upset due to dietary restrictions. The resident then began breathing loudly and did not respond to the nurse. The nurse asked for EMS to be called, then initiated the Heimlich maneuver. The nurse stated they followed the instructions given by EMS dispatch operator until EMS arrived and transferred the resident to the hospital.

During an interview, the resident's family member stated the facility manager notified her of the resident's change in condition and she went directly to the hospital. At the hospital, the physician met with her and stated the resident had died from a stroke.

In conclusion, the Minnesota Department of Health determined 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 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, vulnerable adult is deceased
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.

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
	32457	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEMONT PLACE ALZHEIMER'S SPECIALTY	11748 ULYSSES LANE NE BLAINE, MN 55434

(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 On September 26, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL324576303C/#HL324574784M. No correction orders are issued.	0 000		