Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL325412788M
Compliance #: HL325414780C

Date Concluded: September 19, 2023

Name, Address, and County of Licensee Investigated:
Yorkshire of Edina
7141 York Avenue South
Edina, MN 55435
Hennepin County

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

Evaluator's Name: Danyell Eccleston, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 a resident when they failed to assist the resident with necessary cares according to the resident's individual needs. The resident sustained a skin pressure injury to her right heel.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to provide the resident assistance with cares, including bathing, toileting, and incontinence care. In addition, an outside agency discovered the resident developed a pressure injury on her heel.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted an outside agency that provided care to the resident. The investigation included review of medical records and facility policy and procedure.

The resident resided in an assisted living memory care unit for 25 days after staying in a transitional care facility. The resident's diagnoses included left hip and pelvic surgery, difficulty walking, diabetes, and kidney disease. The resident's discharge summary indicated the service plan included assistance with dressing, grooming, bathing, toileting and incontinence care, and mobility and transfers. The resident's assessment indicated the resident required assistance with dressing and grooming, vital sign monitoring, medication and insulin administration, meal set-up, transferring with two staff members, walking or pushing a wheelchair with one to two staff, toileting and incontinence care, and bathing and showering. Assessments indicated the resident was cognitively intact, able to self-direct cares and make appropriate decisions, and resided at the facility for respite care and not memory care.

Review of facility nurse progress notes indicated on day five of the resident's stay at the facility she tested positive for COVID-19 and remained on isolation precautions until day 15. Progress notes on day 19 of the resident's admission indicated the resident's family was concerned about cares not being completed and requested increased laundry and bathing services. The nurse also documented some of the resident's cares were not completed due to the resident being on COVID-19 precautions. Review of facility nurse progress notes and discharge notes did not include information regarding any skin issues.

Review of outside agency therapy notes from day ten of resident's admission indicated the resident had pitting swelling to both lower legs. Seven days later the therapy notes indicated staff were to assist the resident with sponge baths and ensure the resident received meals on time. Five days later, the therapy notes indicated the resident reported pain to her right heel and a pressure injury was found to the area.

The resident's toileting and incontinence assistance documentation for the 25 days the resident was at the facility indicated there was no documentation of staff providing assistance for greater than nine hours on 14 occasions, six of which were greater than 20 hours between any documented toileting assistance.

The resident's bathing documentation indicated three days prior to discharge the resident refused bathing, and the day prior to discharge she was bathed. There was no documentation the resident was bathed or refused bathing for 22 days after being admitted.

The resident's laundry services documentation indicated staff laundered the resident items for the first time 19 days after admission. No further documentation of completed laundry services was present in documentation provided by the facility.

During an interview, an unlicensed staff stated she would often find the resident soaked in urine. The staff stated the resident did not get bathed when she was supposed to, which is when staff would complete skin checks, and would not have any clean clothes to wear due to her laundry not being washed by staff as indicated. The care giver stated the resident did not

have memory issues and would report staff had not checked on her for long periods of time, she did not always get scheduled meals, and she was wet with urine. The staff stated fellow staff were afraid to enter the resident's room when she was COVID-19 positive, and the resident's cares were not completed as a result.

During an interview, a nurse stated the resident experienced service failures during her admission. When the resident was COVID-19 positive, the resident experienced long wait times when she used her call light for assistance, and a lack of bathing could have been one of the service gaps. The nurse confirmed staff members typically conducted skin checks during bathing services. The nurse also stated the facility had multiple meetings regarding concerns with the resident's care.

During two separate family member interviews, family stated the resident acquired a skin injury to her heel while residing at the facility and the wound still had not healed months later. The family members stated they had concerns regarding the resident not getting the cares that were agreed upon and had concerns for the resident's wellbeing.

During an interview, the resident stated she did not like living at the facility, felt isolated, afraid, and frustrated, and staff seldom answered her call light to assist her. The resident stated there were times she did not get meals or medication in a timely manner. The resident stated she wanted to be bathed and felt dirty while living at the facility.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: The facility held meetings to address the resident's care concerns.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Edina City Attorney
Edina Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32541	A. BUILDING: _____ B. WING _____	C 07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORKSHIRE OF EDINA SENIOR LIVING	7141 YORK AVENUE SOUTH EDINA, MN 55435

(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 ******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: #HL325414780C/#HL325412788M On July 25, 2023, 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 91 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for ##HL325414780C/#HL325412788M, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32541	A. BUILDING: _____ B. WING _____	C 07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORKSHIRE OF EDINA SENIOR LIVING	7141 YORK AVENUE SOUTH EDINA, MN 55435

(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
02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		