Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL350182906M
Compliance #: HL350184904C

Date Concluded: May 28, 2023

Name, Address, and County of Licensee Investigated:
Heritage of Edina
3456 Heritage Drive
Edina, MN 55435
Hennepin County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Substantiated, facility responsibility

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):
The facility and alleged perpetrator (AP) neglected the resident when the resident was found lying on the ground in the patio located next to his apartment window. The resident was admitted to the hospital and passed away two days later due to head injury.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. While the AP did not provide safety checks the time the resident left the building and fell outside is unknown and the impact of the missed safety checks cannot be determined. Additionally, the facility failed to ensure its fire exit door from the secured building would alarm and alert staff members if a resident left the building. When the next shift found the resident outside with a head injury from a fall, he was sent to the hospital where he died two days later from his injuries.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident's records, the AP's personnel record, facility's policies and procedures, incident reports, and the resident's external medical record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia. The resident's service plan included assistance with all activities of daily living which included hygiene, dressing, toileting, medications, meals, and housekeeping. The service plan also included hourly safety check and wander guard check every shift. The resident's assessment indicated he was independent with transfer and mobility. The resident's medical record indicated he had enrolled in hospice about a month prior to the events described in this report.

The resident's incident report and medical records indicated the resident was found at approximately 8:00 a.m. outside of the building on the ground with a possible head injury. The same documents indicated the resident was last seen around 2:00 a.m. The facility contacted 911 and transferred him to the hospital.

The facility conducted an internal investigation which included review of security camera footage indicated the resident had been walking in the hallway over the night shift but was escorted back to his room multiple times over the night. The same document indicated unlicensed caregivers were recorded entering and exiting the resident's room while providing cares for him around 2:00 a.m. No further recorded events were indicated until after 7:00 a.m. when a dayshift unlicensed caregiver entered and exited the resident's room twice. The same document indicated the resident was not recorded leaving his room possibly due to the dimly lit hallway and/or the motion sensor on the camera was not activated. The resident was found outside on the patio at 8:00 a.m. after exiting a fire exit door which was not in view of the camera.

The resident's death record indicated he died two days later due to a fall resulting in a head injury and intracranial (head) bleeding.

During the interview, registered nurse (RN) #1 stated the resident was found fallen outside and had gone out through the fire exit door, which should have been locked at all times. She said the door's battery was malfunctioning, and it did not trigger an alarm when he opened it. Furthermore, she mentioned the door did not have a wander guard system, so the resident's wander guard bracelet did not work on that door. The resident was on hourly safety checks for 24-hours a day, and a camera in the hallway showed the last time staff member leaving the resident's room was at 2:00 a.m. According to the registered nurse, the resident walked independently without any assistive devices and probably tripped on a garden hose, causing him to fall outside.

During an interview, RN #2 stated the resident was wearing a wander guard bracelet and had never attempted to leave the building before. She confirmed that she was working on the day of the incident. When a staff member reported the resident missing, everyone began searching and eventually found him lying outside. 911 was immediately called. The resident had been receiving hourly safety checks, but RN #2 was unsure of when he had last been checked. She also mentioned the door was malfunctioning, which allowed him to exit without triggering an alarm.

During an interview, the AP, who is an unlicensed caregiver, stated he worked on the night of the incident. He reported seeing the resident walking along the hallway and noticed the resident needed to be cleaned up, so he and another caregiver brought the resident to his room and provided cares. The AP stated he did not perform hour safety check on the resident because he was not aware that the resident was assigned to him. He also stated that the night of the incident was not his first time working in that building as he works through a staffing agency and had worked there for two weeks prior to this occurrence.

During an interview, the director stated the resident was found outside the facility in the garden area. Although the hallway had a camera, it was dark, and the resident was not recorded leaving the building. It was unknown how long the resident had been outside. While the resident had a functional wander guard, it did not work on the malfunctioned fire exit door, so the maintenance team had since changed the battery. The director did not know when the fire door had last been checked prior to this incident. She stated the resident was on hourly safety checks, but the caregiver assigned to him this shift said he did not know he was responsible for him. She said unlicensed caregivers are provided two books to review with the necessary cares and the caregiver may have not reviewed his assignment for the shift.

During an interview, the director of maintenance stated he checked the fire exit door after the incident and discovered a dead battery had caused the door not to sound the alarm. He also stated the door was supposed to alarm if the door was opened but he did not know the battery needed to be replaced. He stated he checked the batteries monthly although he did not have any documentation of his checks. After the incident, he began checking all the fire exit doors weekly to ensure that they were functioning correctly and documented each check on paper.

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: No, the resident is deceased.
Family/Responsible Party interviewed: No, attempts to interview unsuccessful
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility initiated an internal investigation. The facility chose to no longer use the AP as a caregiver at the facility. The facility provided education to all its caregivers regarding safety checks and notifying the nurse if a resident cannot be located. Furthermore, the facility began checking all fire exit doors weekly and documenting the checks to ensure they were functioning correctly.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35018	A. BUILDING: _____ B. WING _____	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE OF EDINA INC	3456 HERITAGE DRIVE 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 LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investgation. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL350184904C/HL350182906M. On March 30, 2023 the Minnesota Department of Health conducted an investigation at the above provider, and the following correction orders are issued: 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. 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.	02360	No plan of correction is required for this tag.	

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02360	Continued From page 1 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		