Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308247485M
Compliance #: HL308244055C

Date Concluded: December 20, 2023

Name, Address, and County of Licensee Investigated:
Edgewood Assisted Living
4195 Westberg Road
Hermantown, MN 55811
St. Louis County

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

Evaluator's Name: Brandon Martfeld, RN
Special Investigator

Finding: Substantiated, individual 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 alleged perpetrator (AP) abused a resident when the AP threw the walker across the room which resulted in the resident being fearful of the AP.

The AP neglected the resident when the AP failed to provide the resident with incontinent care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Due to conflicting information provided by the resident there was not a preponderance of evidence the AP threw the resident's walker across the room.

The allegation of neglect is substantiated. The AP was responsible for the maltreatment. After the resident had a bowel movement, the AP did not provide care to the resident which left the resident soiled with feces.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator completed interviews with the AP and the resident. The investigation included review of the resident's medical record, personnel file, facility investigation, and facility policies. Also, the investigator completed a facility tour.

The resident resided in an assisted living facility. The resident's diagnoses included irritable bowel syndrome with diarrhea, depression, and anxiety. The resident required assistance of one staff with toileting, incontinent care every two hours, and urinary catheter care every eight hours. The resident used a walker and was independent with walking and transfer. The resident's assessment indicated the resident was alert and oriented.

The facility investigation indicated the resident reported she pushed her call light around one early morning. The AP came into the room, threw the resident's walker from the bathroom into the living room, and assisted the resident from the bathroom into a recliner chair without completing incontinent care after using the toilet. The resident indicated the AP came back to the resident's room about two hours later and did not provide incontinent care. During an investigation the AP was interviewed and denied leaving the resident soiled without performing incontinent care and became angry with leadership.

The resident's service delivery record indicated the AP documented providing the resident incontinent care at 1:07 a.m.

During an interview, the resident stated she rang for help after using the bathroom. The AP came into the room, stated he forgot his gloves and never came back into the room. The resident stated after waiting for hours, the resident rang again for assistance and a different staff person came in and completed cares. The resident stated the AP did not throw her walker but moved it from the bathroom into the living room.

During an interview, unlicensed staff member stated the morning following the incident, the resident requested assistance within five minutes of the day shift starting. The unlicensed staff member stated when she entered the resident's room, she found the resident crying, upset with feces down both her legs and the resident's urinary catheter bag was full of urine. The unlicensed staff member stated the feces was dried and hard. The ULP stated she washed the resident with warm, soapy water. The ULP stated the resident said the AP left her on the toilet and never came back so the resident made her way back to her recliner chair. The unlicensed staff member stated at the change of shift, the AP reported the resident's incontinent care and catheter care had been completed for the resident an hour before shift change.

During an interview, the AP stated there was a resident covered in feces, but the AP did not assist the resident. The AP stated he charted the resident's cares as completed; however, he never completed the cares.

During an interview, leadership stated the resident reported when she called for help, the AP came into the room but did not assist the resident with incontinent cares. The next morning unlicensed staff member found the resident incontinent of feces and assisted the resident. Leadership stated the AP denied the allegation.

In conclusion, the Minnesota Department of Health determined neglect was substantiated and abuse was not 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.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening

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: No. Resident was responsible for self.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation. The AP no longer is employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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
St. Louis County Attorney
St. Louis City Attorney
Hermantown Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30824	A. BUILDING: _____ B. WING _____	C 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD HERMANTOWN I SENIOR LIVING	4195 WESTBERG ROAD HERMANTOWN, MN 55811

(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: #HL308247485M/#HL308244055C On October 18, 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 186 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL308247485M/#HL308244055C, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 evaluators' 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 144G.31 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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 reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	