STATE LICENSING COMPLIANCE REPORT

Report #: HL335628229C

Date Concluded: September 17, 2024

Name, Address, and County of Facility Investigated:
Edgewood Place
6517 Edgewood Avenue North
Brooklyn Park, MN 55428
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, 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 (for ALL). 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
	33562	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD PLACE	6517 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428

(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, this correction order is 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: #HL335628229C On September 16, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 0 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL335628229C, tag identification 1070.	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.	
01070 SS=G	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any	01070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33562	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD PLACE	6517 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428

(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
01070	Continued From page 1 reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee refused to allow one of one residents (R1) to return after a hospitalization. This had the potential for serious harm to R1 as she required total staff cares due to left side paralysis, a tracheostomy in place, and gastrostomy tube in place. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1 admitted to the facility on March 15, 2023, due to diagnoses that included hemorrhagic stroke with left side paralysis, tracheostomy, hypertension, hepatitis C, methicillin-resistant staphylococcus aureus, and suicidal ideation. R1's service plan dated March 15, 2023, indicated R1 received services from the licensee that included 14 hours per day of home care nursing, medication administration, assessment by a registered nurse, twice daily vital sign checks, daily nutrition, and behavior monitoring.	01070	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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33562	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD PLACE	6517 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428

(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
01070	Continued From page 2 R1's assessment dated August 14, 2024, indicated R1 was totally dependent on staff for all cares due to left side paralysis, placement of a tracheostomy, placement of a gastric tube for medications/hydration/nutrition due to inability to swallow "even her own saliva", and had a history of aspiration pneumonia. The assessment indicated staff provided tracheostomy cares, including suctioning as needed. The assessment indicated R1 had pulled out her tracheostomy tube when in respiratory crisis and was her own guardian. R1's progress note dated August 15, 2024, at 9:31 p.m. indicated registered nurse (RN)-A determined R1 was in "stable condition, afebrile, with vital signs within normal range". R1's progress note dated August 16, 2024, at 10:52 p.m. indicated R1 was, "doing fine". R1's progress note dated August 17, 2024, at 2:23 p.m. indicated R1, was "very fine throughout the day". R1's progress note dated August 18, 2024 at 6:47 a.m. indicated R1, "appeared fine" and when asked if she was in pain, "she said she is okay". R1's hospital record dated August 18, 2024, at 8:05 a.m. indicated facility staff called 911 due to R1 "having trouble" with her tracheostomy overnight with worsening cough and excessive mucus production. The record indicated the hospital attempted to get in contact with the nurse for additional information but were unsuccessful. The record indicated the hospital observed excessive amounts of yellow colored mucus at the opening of R1's tracheostomy and after suctioning the mucus was clear, and R1's lungs	01070	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33562	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD PLACE	6517 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428

(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
01070	Continued From page 3 were clear to auscultation bilaterally, with no wheezes or accessory muscle use. Hospital labs indicated no signs of infection. R1's hospital record dated August 19, 2024, at 9:10 a.m. indicated RN-A reported to the hospital during a phone call, that R1's increased thick, yellow sputum production "started roughly two days ago" and had been worsening. R1's hospital record dated August 19, 2024, at 2:52 p.m., indicated the hospital social worker spoke with RN-A, who requested R1 find other housing because two facility staff resigned over the weekend and the facility did not have enough staff to properly care for the resident. A letter dated August 21, 2024, from administrator/owner (A/O)- B to R1 indicated the facility had to, "make some changes ordered by MDH" [Minnesota Department of Health] and "we are no longer able to handle your case, we are not able to have you discharged back to Edgewood we don't have the staff and we are sorry to inform you with such short notice". The letter further indicated "This is a notice the [facility] will have to terminate your lease and suspended your service agreement." During an interview on September 11, 2024, at 12:44 p.m. RN-A stated R1 was "taken to the hospital and we discharged her. They are going to find her a new place." During an interview on September 11, 2024, at 1:48 p.m. A/O-B stated "MDH required an RN 24/7. The other resident was moved to another of our facilities, [R1] was discharged to the hospital, and we closed the facility."	01070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33562	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD PLACE	6517 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428

(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
01070	Continued From page 4 During an interview on September 16, 2024, at 10:59 a.m. hospital social worker stated R1 remained inpatient at the hospital at the time of the investigation (four weeks after admission), with physician notes indicating she was medically stable for discharge. Discharge policy requested, but not received. Time period for Correction: Seven (7) days.	01070		