Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL324571261M
Compliance #: HL324572089C

Date Concluded: October 31, 2022

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

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

Evaluator's Name:
Katie Germann, RN, Special Investigator
Maerin Renee, RN Special Investigator

Finding: Inconclusive

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 neglected two residents when resident (R2) pushed resident (R1) to the floor, resulting in R1 breaking his hip.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although it was alleged R2 pushed R1 to the floor, there were no witnesses and the cause of R1's fall could not be determined.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted residents' family members. The investigation included review of medical records, hospital notes, progress notes, incident reports, and service contracts. In addition, the investigator observed staff and resident interactions.

The resident (R1) resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease, osteoporosis, weakness, anxiety, and behavioral disturbance. The resident's service plan included assistance with activities of daily living, shower assistance, medication administration, safety monitoring, and housekeeping. The resident's assessment indicated cognitive impairment and a moderate risk for falls.

The resident (R2) resided in an assisted living memory care unit. The resident's diagnoses included dementia, traumatic brain injury, restlessness, and agitation. The resident's service plan included assistance with activities of daily living, shower assistance, medication administration, safety monitoring, and housekeeping. The resident's assessment indicated cognitive impairment, depression, and history of physical/verbal aggression.

R1 fell and sustained a femur fracture requiring surgical intervention.

During an interview, an unlicensed staff member stated she helped respond to the fall after she heard R1 scream. She saw R2 in the area where R1 fell, but R1 was already on the floor when the unlicensed staff member arrived at the scene. The unlicensed staff member did not witness R2 push R1 to the floor.

When interviewed a nurse stated he was unable to recall the details of R1's fall. However, the residents progress notes indicated the nurse documented he responded to the incident and provided care to R1.

When interviewed a former management staff stated a nurse reported R2 had pushed R1 which resulted in R1 falling and breaking her femur. The management staff stated she was not sure if the nurse witnessed the incident or just responded to the incident. Regardless, no updated interventions for supervision were initiated.

During an interview with a previous supervisor, she stated it was reported to her R2 pushed R1 to the floor. However, she did not recall who reported this or if the alleged altercation was witnessed.

When interviewed the current administrator stated there might have been an internal investigation of the incident, but she was not sure where it would be located.

Review of R1's progress notes documented by a nurse on duty that evening indicated R1 had been pushed to the floor by R2. R1 was sent to the hospital after complaining of hip pain, and was diagnosed with a fracture.

Review of R2's individual abuse prevention plan indicated a history of physical and verbal aggression. The facility had no documentation of interventions in place to prevent future incidents of physical and verbal aggression toward other residents.

R1’s family member stated the facility did not provide an update regarding R1’s hospitalization. The family only learned of the hospitalization when they called the facility the next morning to inquire about R1’s condition and the alleged cause of her fall. The family opted to move R1 out of the facility due to concerns for her safety.

R2’s family member stated she was never notified of the incident and the facility had not provided an update. She reported R2 had a history of altercations with other residents.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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, due to cognitive impairment.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action was taken by the facility.

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.

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 10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEMONT PLACE ALZHEIMER'S SPE	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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL324572089C/#HL324571261M On October 5, 2022, 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 48 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL324572089C/#HL324571261M, tag identification 0630, 0900, 1460, 1490, 2110, and 3000.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure an individual abuse prevention plan (IAPP) was developed to include statements of the specific measures to be taken to minimize the risk of abuse for one resident (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). The findings include: R2's medical record was reviewed. R2 was admitted to the facility on March 20, 2020. R2's diagnoses included dementia, traumatic brain injury, and restlessness and agitation. R2's service plan dated November 21, 2021,	0 630		

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0 630	Continued From page 2 indicated R2 received services for assistance with daily living, nursing assessments, and medication management. R2's service plan indicated psychosocial vulnerabilities including moderate memory impairment, disorientation, history of disruptive, aggressive, or socially inappropriate behavior, either verbally or physically. There was no documentation of specific interventions to manage R2's behaviors. R2's Individual Abuse Prevention Plan, (IAPP), dated November 10, 2021, indicated vulnerabilities including past physical and verbal aggression. Interventions included the use of redirection to remove R2 from triggering situations. The IAPP did not specify circumstances that triggered R2's behaviors of physical or verbal aggression, nor did it address prevention efforts. R2's IAPP lacked statements of specific measures to be taken to minimize the risk of abuse to other residents. During an interview on October 5, 2022, at 1:30 p.m., the executive director (ED)-B stated with the change in ownership, some documentation cannot be found at this time, so updates might not be reflected in the documentation provided to investigators. A policy addressing the abuse prevention plan was requested but not provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	0 630		

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0 900	Continued From page 3	0 900		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.	0 900		

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0 900	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to develop and execute an assisted living written contract to include all required content for two of two (R1 and R2) residents with records reviewed. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 began receiving assisted living services on January 27, 2022. R1 had a service contract signed and dated January 26, 2022. Review of R1's care plans from May, 2022 indicated R1 received services including activities of daily living, medication administration, and weekly bathing assistance. R2 began receiving assisted living services on March 20, 2020. R2 had a service contract signed and dated March 20, 2020. Review of R2's service plan dated November 21, 2021, indicated R2 received services including activities of daily living, medication administration, and weekly bathing assistance. On February 1, 2022, the facility underwent a change in ownership. R1 and R2's records lacked	0 900		

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0 900	Continued From page 5 evidence of updated, signed contracts or contract addendums with the new owner of the facility. On October 17, 2022, at 9:50 am, R1's family member said they only received the original contract from January 26, 2022. He never received or signed a new contract when the facility changed ownership on February 1, 2022. On October 17, 2022, at 9:05 am, R2's family member said that she never received or signed a new contract after the facility changed ownership on February 1, 2022. The facility's policy and procedure manual dated May 20, 2022, lacked policies related to service contracts that included the following required content: - Offer prospective residents and provide to the Office of the Ombudsman for Long-Term Care a complete unsigned copy of its contract; and - Give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; - Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative; - The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. A policy addressing assisted living contracts was requested but not provided.	0 900		

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0 900	Continued From page 6 TIME PERIOD FOR CORRECTION: Fourteen (14) days.	0 900		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview. and record review, the facility failed to provide staff orientation to assisted living licensing requirements and regulations for three of three employees (unlicensed personnel [ULP]-C, D, and E) with records reviewed. This had the potential to affect all residents receiving services from the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents) The findings include:	01460		

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01460	Continued From page 7 ULP-C was hired on January 19, 2021, under the facility's comprehensive home care license. ULP-C began providing assisted living services on August 1, 2021. ULP-D was hired on May 16, 2018, under the facility's comprehensive home care license. ULP-D began providing assisted living services on August 1, 2021. ULP-E was hired on May 24, 2022, to provide assisted living services to the facility's residents. All three employee records lacked documentation indicating they were oriented to assisted living requirements in accordance with 144G statutes. On October 5, 2022, at 10:05 a.m., ULP-C was observed assisting a resident with ambulation. During an interview on October 5, 2022, at 1:30 p.m., the executive director (ED)-B stated with the change in ownership, some documentation cannot be found at this time, so all training records might not be reflected in the documentation provided to investigators. A policy titled Staff Training, dated May 20, 2022, indicated all training will be documented and copies of documentation will be retained in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01460		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia	01490		

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01490	Continued From page 8 All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff received dementia training in the required areas for three of three employees (unlicensed personnel [ULP]-C, D, and E) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility obtained an Assisted Living License on August 1, 2021. ULP-C was hired January 19, 2021, under the facility's comprehensive home care license. ULP-C began providing assisted living services on August 1, 2021, to provide dementia care services to the residents. ULP-D was hired May 16, 2018, under the facility's comprehensive home care license. ULP-D began providing assisted living services on August 1, 2021. ULP-E was hired May 24, 2022, to provide	01490		

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01490	Continued From page 9 assisted living services to residents. All three employee files lacked dementia care training in accordance with 144G statutes. During an interview on October 5, 2022, at 1:30 p.m., the executive director (ED)-B stated with the change in ownership, some documentation cannot be found at this time, so all training records might not be reflected in the documentation provided to investigators. A policy titled Staff Training, dated May 20, 2022, indicated all training will be documented and copies of documentation will be retained in the employee record. Dementia care was listed as a training topic. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	01490		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event	02110		

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02110	Continued From page 10 a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure the assisted living facility with dementia care developed policies and procedures that address the required ten provisions noted in 144G.82 Subd. 3 for two of two residents (R1 and R2) with records reviewed. This had the potential to affect all residents in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	02110		

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02110	Continued From page 11 The findings included: The facility failed to develop and implement specific dementia care policies and procedures that addressed the following required provisions: -philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; -evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; -wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; -medication management, including an assessment of residents for the use and effects of medication, including psychotropic medications; -staff training specific to dementia care; -description of life enrichment programs and how activities are implemented; -description of family support programs and efforts to keep the family engaged; -limiting the use of public address and intercom systems for emergencies and evacuation drills only; -transportation coordination and assistance to and from outside medication appointments; and -safekeeping of resident's possessions. During an interview on October 5, 2022, at 11:30 a.m., the executive director (ED)-B stated the policy and procedure book she was provided with contained the policies that she was aware of for the facility.	02110		

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 10/05/2022

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

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02110	Continued From page 12 Dementia care policies were requested but not provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	02110		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has	03000		

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03000	Continued From page 13 reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment within 24 hours for two residents (R1 and R2), with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). The findings include: R1's medical record indicated the resident was admitted to the facility on December 30, 2021. R1's diagnoses included Alzheimer's disease,	03000		

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03000	Continued From page 14 osteoporosis, weakness, behavioral disturbance, and anxiety disorder. R1's progress notes dated May 22, 2022 indicated a licensed practical nurse (LPN)-F reported R1 was shoved to the floor by another resident (R2) resulting in R1 being sent to the hospital that evening and was diagnosed with a fractured hip. Review of the Minnesota Adult Abuse Reporting Center (MAARC) report indicated the facility did not report the incident to MAARC until May 25, 2022, 3 days after the incident occurred. During an interview on October 5, 2022, at 1:30 p.m., the executive director (ED)-B stated with the change in ownership, some documentation cannot be found at this time, and was not aware of documentation for an internal investigation of the incident. A policy addressing vulnerable adult reporting was requested but not provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	03000		