DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL34426007M
Compliance #: HL34426008C

Date Concluded: August 12, 2022

Name, Address, and County of Facility Investigated:
Elk Ridge Alzheimer's Special Care Center
1700 Beam Avenue
Maplewood, MN 55109
Ramsey County

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

Evaluator's Name: James Larson, 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.

Allegation(s):
The facility neglected the resident when staff failed to provide pain management medication.

Investigative Findings and Conclusion:
Neglect was not substantiated. Medication was provided to the resident in accordance with physician orders.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator interviewed hospice staff members and the resident's family. The investigation included review of the resident's medical record, hospice records, nursing assessments, service plans, care plans, falls, progress notes, health care directives and death record. The investigator also observed staff interaction with residents.

The resident’s diagnoses included Alzheimer's Disease, dementia, and hypertension. The resident’s plan of care indicated she was receiving comfort measures only which included assistance with dressing, grooming, bathing, and medication management. The resident was unresponsive and was not able to eat or verbalize her needs. Facility staff were directed to anticipate the resident’s needs, monitor for non-verbal signs of discomfort and administer pain medication per physician orders.

The day the incident occurred, a hospice nurse observed the resident to have an increase in restlessness and pain. The nurse was concerned and questioned facility staff on the resident’s most recent pain medication administration time. Staff working at the time were unaware of when the resident last received medication and could not provide explanation to the resident’s increased level of pain or restlessness.

The hospice nurse later spoke with additional facility staff, reviewed documentation in the resident’s chart and determined the facility had provided medication in accordance with physician orders.

During an interview with the hospice nurse, she confirmed the resident received medications as ordered and indicated pain medications were increased for the resident’s comfort.

The resident’s family was interviewed and had no concerns about the care provided at the facility.

In conclusion, neglect was not substantiated.

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

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.

Vulnerable Adult interviewed: No, resident deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action required.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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
	34426	A. BUILDING: _____ B. WING _____	C 06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELK RIDGE ALZHEIMER'S SPECIAL	1700 BEAM AVENUE MAPLEWOOD, MN 55109

(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 On June 22, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL34426008C/#HL34426007M. No correction orders are issued.	0 000		