Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308241762M
Compliance #: HL308242765C

Date Concluded: July 29, 2025

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

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

Evaluator's Name: Deb Schillinger RN BSN
Special Investigator

Finding: Not Substantiated

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 facility neglected the resident when medication was not administered as ordered. The resident developed sepsis and died in the hospital four days later.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although, the resident did not receive the medication for the urinary tract infection (UTI), the facility staff made numerous phone calls and fax communications to the medical provider and pharmacy in an attempt to coordinate and expedite delivery and administration of the medication. During the investigation it was discovered the medication ordered after the initial urinalysis (UA) was found to not be the best antibiotic to treat the UTI after the final results from the urine culture and sensitivity were received by the facility the same day the resident was transferred to the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, death record, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Hospital records were requested but not received. Also, the investigator toured the facility and observed interactions between facility staff members and residents during the onsite visit.

The resident resided in a secured assisted living memory care unit. The resident's diagnoses included a recent cognitive decline, chronic pain, and chronic kidney disease. The resident's service plan included assistance with medication management and administration, dressing and toileting. The resident's assessment indicated a recent decline in cognition, needed frequent reminders and used a walker for ambulation.

The resident readmitted to the facility on the 19th day of the month after receiving short term therapy in a transitional care facility for a previous hospitalization for a sudden onset of lethargy (marked drowsiness and an unusual lack of energy and mental alertness).

On the 27th day of the month, four days before the hospitalization, the resident had an appointment with a physician regarding chronic hip pain where her gabapentin dose (a medication used to treat nerve pain and seizures) was increased.

The next day, on the 28th day of the month, a progress note in the resident's medical record indicated the resident's gabapentin dose was increased and later in the afternoon, a urinalysis (UA) was obtained after reports of foul-smelling urine. The same note indicated the resident was not experiencing urinary pain or other symptoms at that time. Later that evening, preliminary lab results were received by fax at the facility.

On Saturday, the 29th day of the month the facility on-call nurse contacted the medical provider as the facility, nor the pharmacy had received orders regarding the UA results the previous day. The facility nurse faxed the UA results to the medical provider for review and to order medications, if warranted. A progress note indicated the facility requested new medication orders be sent to a local pharmacy for faster delivery and administration. The on-call medical provider ordered an antibiotic for the resident and sent an electronic prescription to the pharmacy. The pharmacy faxed a copy of the prescription received to the facility. (It was unclear if the prescription was sent to a local pharmacy by the medical provider as requested.)

On Sunday, the 30th day of the month, the on-call nurse was updated by the facility staff the medication had not yet arrived at the facility and the resident was now having trouble walking. A progress note indicated the difficulty walking was contributed to the recent increased gabapentin dose. The note went on to indicate the on-call nurse contacted the pharmacy to inquire when the antibiotic would arrive and was told it had been shipped and would arrive that day. The on-call nurse instructed the facility staff to hold the afternoon dose of gabapentin, if

the resident did not want to take it and follow up with the provider of the resident's concerns on the next day (Monday).

Later that morning on Sunday, the completed urinalysis with culture and sensitivity results were received by fax at the facility and forwarded to the medical provider. The results indicated the medication ordered initially was not the best choice to treat the organism causing the UTI.

The resident's medical record indicated on Sunday later in the afternoon, the resident began not feeling well and began shaking. Per resident and family member request, emergency medical services (EMS) were called, and the resident was transferred to the hospital for evaluation. The note indicated the facility staff notified EMS of the resident's current urinary tract infection and medications had not yet arrived to start administration.

Medical records received indicated the resident admitted to the hospital with urosepsis (a system wide infection in the body that originates as a urinary tract infection). The records received indicated the resident did not receive antibiotics at the hospital because the resident was placed on comfort care. The resident died four days later.

During an interview, the nurse stated the facility staff and on call nurse acted within their ability. The facility on-call nurse made requests to the provider and pharmacy staff to send the new medication order to a local pharmacy for faster delivery, however the medication order was sent through the mail delivery system. The nurse stated when the family reported the resident was experiencing a change in condition to unlicensed caregivers, EMS was notified, and the resident was transferred to the hospital for evaluation.

During an interview, the family member reported she had taken the resident to see a medical provider about chronic hip pain, after that visit she became concerned the resident was experiencing an infection and updated a facility unlicensed caregiver. The following day she inquired if a urinalysis was completed before taking the resident out to lunch, and a UA was obtained by facility staff and sent to the laboratory. The family member asked on Saturday if family could pick up the medication, and the facility staff said the medication was sent to the mail order pharmacy. On Sunday, the family member reported the resident did not complain of urinary pain or difficulty urinating but was having difficulty walking and declined to go to church that morning. By the afternoon, the resident did not feel well and began shaking. An unlicensed caregiver notified EMS, after family members request. The resident's condition continued to progressively decline and ultimately was unable to recognize her family. Upon admission to the hospital, the resident was put on comfort care and died four days later.

In conclusion, the Minnesota Department of Health determined 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.

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.
(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

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

Action taken by facility:
The facility on call nurse made follow up calls to the on-call provider and pharmacy, made good faith attempts to coordinate and expedite medication delivery. The facility unlicensed caregiver contacted EMS after a change in condition was reported by family and the resident was transferred to the hospital for evaluation and treatment.

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
	30824	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD HERMANTOWN I SR LVG	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 On May 21, 2025, the Minnesota Department of Health initiated an investigation of complaint HL308242765C/HL308241762M. No correction orders are issued.	0 000		