Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL265856329M
Compliance #: HL265859574C

Date Concluded: November 22, 2024

Name, Address, and County of Licensee Investigated:
Edgewood Sartell
673 Brianna Drive
Sartell, MN 56377
Stearns County

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

Evaluator's Name: Lena Gangestad, RN
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 the resident was found on the floor with bleeding from his nose and mouth. The resident was transferred to the hospital and passed away three days later.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident did fall multiple times during the five-day period, the facility provided appropriate care each time.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigation included review of the resident's records, incident reports, staff schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia. The resident's service plan included assistance of one person with all activities of daily living which included hygiene, dressing, toileting, medications, and meals. The service plan also included thirty-minute safety check every shift. The resident's assessment indicated he was independent with transfers and mobility.

One week the resident began to experience increased falls.

On Tuesday, a staff member found the resident lying on his back in the medication room. No injuries were noted. The nurse and primary care provider were notified. The facility updated the medical provider who gave orders for outpatient physical and occupational therapy orders. The facility faxed the order to the therapy agency.

On Wednesday, a staff member contacted the on-call nurse and reported the resident attempted to sit down on a chair in his apartment but missed the chair and fell, hitting his head on the wall. The facility called emergency services, and the resident was transferred to the emergency room. He returned to the facility the next day with no new orders and ambulating at his baseline.

On Thursday, the resident fell at 5:45 AM with no injuries noted. Later the same day at 12:30 PM, the resident fell again but with no injuries. Later that evening near 6:00 PM, the resident was found on the floor again this time bleeding profusely from his nose and mouth after hitting his head on the doorway. These falls occurred despite staff checking on him every thirty minutes. The facility notified the family and the medical provide and subsequently sent the resident to the hospital, where he died three days later.

During an interview, unlicensed caregiver #1 stated the resident was able to ambulate independently, and staff had been instructed to keep an eye on him. She said that the resident was on a thirty-minute safety check schedule, and she was on-duty when the resident fell the last time. Unlicensed caregiver #1 stated a co-worker said she had just checked on the resident and saw him sleeping on a couch. A few minutes later, they both heard the resident yelling for help. Upon reaching his room, the resident was found on the floor and bleeding from his head so the called 911.

During an interview, unlicensed caregiver #2 stated that when providing care, she would assist the resident in getting dressed, which he was generally able to complete on his own most days. Unlicensed caregiver #2 stated the resident occasionally needed help with personal hygiene and/or toileting. She said the resident was mostly independent with movement throughout the majority of his stay. He could remove and put on his pants while standing. The resident typically spent his days in the common areas, but when he was in his room, he would either watch TV or color. She stated that she performed safety checks, ensured the floor was clear, and made sure he had appropriate shoes to help prevent falls.

During an interview, unlicensed caregiver #3 stated the resident's behavior became more pronounced after he returned from geriatric psychiatric care not long before his falls occurred. The resident began to experience hallucinations and waking by himself. She said offered to walk with him using a gait belt, as he was a tall individual to calm him.

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.

Vulnerable Adult interviewed: No. The resident was deceased.
Family/Responsible Party interviewed: No, attempted but did not reach.
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
	26585	A. BUILDING: _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD SARTELL LLC	677 BRIANNA DRIVE SARTELL, MN 56377

(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 November 7, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL265856329M/HL265859574C. No correction orders are issued.	0 000		