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 #: HL28353003M
Compliance #: HL28353004C

Date Concluded: October 21, 2022
Date Amended: March 10, 2025

Name, Address, and County of Licensee Investigated:
The Encore at Mahtomedi
720 Mahtomedi Avenue
Mahtomedi, MN 55115
Washington County

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

Evaluator's Name: Stacia Hansen, RN
Special Investigator
Amended By: Matt Heffron, JD, NREMT
Operations Manager

Allegation #1 Finding: Not Substantiated

Allegation #2 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):

Allegation #1: The facility neglected the resident when medications were not administered as ordered by the provider.

Allegation #2: The alleged perpetrator (AP) abused a resident when the AP unreasonably confined the resident in her room by locking the resident's door.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While a medication error did take regarding scheduled morphine, the investigation did not find the resident experienced untreated pain.

However, the Minnesota Department of Health determined abuse was inconclusive ~~substantiated~~. ~~The AP was responsible for the maltreatment.~~ While the AP denied locking the door during the investigation interview, the facility provided documentation indicating the AP did lock the resident's door during an overnight shift. The investigation did not determine whether the resident was unreasonably confined.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the hospice nurse and hospice social worker. The investigation included review of employee training records, resident record, policies and procedures, and incident report. Also, the investigator toured the facility and observed staff transferring the resident from her wheelchair into bed.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, stroke, and pain related to recent fall. The resident's service plan included assistance with dressing, grooming, toileting, and medication administration. The resident's assessment indicated she was able to walk with a walker but had recent falls.

Allegation #1

The resident's physician orders indicated the provider discontinued morphine 2.5 milligrams (mg) at bedtime and APAP (acetaminophen) 1000 mg twice daily and to start morphine 2.5 mg three times daily and APAP 1000 mg every 6 hours as needed for pain.

However, the resident's medication administration record (MAR) for the indicated medications included APAP 1000 mg every 6 hours as needed for pain. The same document did not indicate the resident received scheduled morphine 2.5 mg three times daily for the month following the provider's orders. The resident's MAR did not reflect the provider's order for morphine 2.5 mg every 6 hours until a month later. The resident's MAR indicated the resident continued to get morphine 2.5 mg at bedtime but otherwise the resident did not get morphine on a scheduled basis although morphine was available on an PRN (as needed) basis.

The resident's hospice records indicated the resident experienced pain one visit during a procedure to remove staples placed to treat a laceration sustained during a fall. Otherwise, the same documents indicated the resident denied pain and/or did not document nonverbal indicators of pain.

During an interview, the nurse stated when she started working for the facility, they were using a different pharmacy and she was advised by her supervisor she did not need to put medication orders on the MAR at that time. The nurse stated she faxed the resident's medication orders to the new pharmacy, but the pharmacy did not enter it into the resident's MAR due to it being a controlled substance. The nurse stated later she and the facility realized it was her responsibility to enter this type of order on the resident's MAR.

During an interview, the hospice nurse stated the facility had access to a portal where the provider enters in medication orders. The hospice nurse stated she discovered the resident was not taking her scheduled morphine that was ordered by the provider after talking to the home health aide during an onsite visit about a month after the provider ordered morphine 2.5 mg three times a day.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

Allegation #2

One night the resident's family member arrived at the facility to visit the resident, but she found the door to the resident's room was locked. In time, the AP unlocked the door for the resident's family member to enter the resident's room. <u>It could not be determined whether the resident was able to exit the room while the door was locked from the outside</u>

A facility incident report indicated the AP was not immediately located when a family member arrived because the AP was making their rounds, however many secured locations within the floor are key-accessed and family members would not have access to these areas. The same document indicated the AP said that he locked the door for privacy due to another resident that was wandering the hallways that evening according to the incident report.

During an interview, the nurse stated the AP originally reported to her that the evening shift must have locked the resident's door. ~~The nurse stated the AP later admitted he locked the resident's door.~~

During an interview, the AP stated when the family member arrived during an overnight shift he was attending to other residents. The AP stated he and the family member walked together to the resident's room and he did not need a key to open the door because it was only closed and not locked.

During an interview, the family member stated she arrived at the facility at approximately 3:00 a.m. to check on her mother and the door to enter her room was locked. The family member stated the AP said he had locked the resident's door to protect her from another resident who was wandering.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show maltreatment did or did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult;

Vulnerable Adult interviewed: No, due to dementia diagnosis
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility provided reeducation for the nurse on the correct process for working with provider medication orders. Also, the facility investigated the complaint regarding the resident's door being locked.

Action taken by the Minnesota Department of Health:
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.

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Mahtomedi Police Department
Mahtomedi City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28353	A. BUILDING: _____ B. WING _____	C 07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCORE AT MAHTOMEDI	720 MAHTOMEDI AVENUE MAHTOMEDI, MN 55115

(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: #HL28353004C/#HL28353003M On July 20, 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 34 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL28353004C/#H28353003M, tag identification 0460.	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 460 SS=D	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure staff did not lock a resident door for one of one resident (R1) 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, but was not likely to cause 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). The findings include: R1 s medical record was reviewed. R1 was	0 460		

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0 460	Continued From page 2 admitted on December 15, 2020, and had diagnoses including dementia, depression, schizophrenia, and stroke. R1's Service Plan dated January 12, 2022, indicated R1 received assistance with dressing, grooming and toileting, and medication administration. The licensee's document titled "Complaint Overview", dated June 23, 2022, indicated a staff member was not immediately located upon a family member arriving because the staff member was making their rounds. The complaint overview indicated the staff member reported that he locked the door for privacy due to another resident that was wandering the hallways that evening. During an interview on July 20, 2022, at 1:47 p.m., registered nurse (RN)-A stated the unlicensed personnel (ULP)-D originally stated to her the evening shift must have locked the resident's door. RN-A stated the staff member later admitted he only locked the one resident's door. During an interview on July 25, 2022, at 11:06 a.m., family member (FM)-B stated she arrived around 3 a.m. and found the door to the resident's room locked. The family member stated she was told the staff member had locked the resident's door to protect her from another resident who was wandering. During an interview on July 28, 2022, at 11:21 a.m., ULP-D stated when the family member arrived, he was attending to other residents. ULP-D stated he and the family member walked together to the resident's room and he did not	0 460		

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0 460	Continued From page 3 need a key to open the door because it was only closed and not locked. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure medications were administered per provider orders for one of one residents (R1) 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, but was not likely to cause 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	01760		

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01760	Continued From page 4 situation has occurred only occasionally). Findings include: R1's medical record was reviewed. R1 was admitted on December 15, 2020, and had diagnoses including dementia, depression, schizophrenia, and stroke. R1's Service Plan dated January 12, 2022, indicated R1 received assistance with dressing, grooming and toileting, and medication administration. R1's Physician Orders form dated January 24, 2022, indicated R1's provider requested to discontinue morphine 2.5 mg (milligrams) at bedtime and APAP (acetaminophen) 1000 mg twice daily then prescribed to start morphine 2.5 mg three times daily and APAP 1000 mg every 6 hours as needed for pain. R1's Medication Administration record (MAR) dated January 2022, indicated R1's scheduled medications included morphine 2.5 mg three times daily was entered on January 24, 2022 but had a stop date of January 25, 2022. The January 2022 MAR indicated that APAP 1000 mg twice daily was stopped on January 24, 2022 and APAP 1000 mg every 6 hours as needed for pain was started on January 24, 2022. R1's MAR dated February 2022, indicated R1's medications included APAP 1000 mg every 6 hours as needed for pain but did not include scheduled morphine 2.5 mg three times daily. R1's MAR dated March 2022, indicated R1's scheduled medications included a new order initiated on March 1, 2022, for morphine 2.5 mg	01760		

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01760	Continued From page 5 every 6 hours. During an interview on July 20, 2022, at 1:47 p.m., registered nurse (RN)-A stated when she started working for the facility they were using a different pharmacy and she was advised by her supervisor she did not need to put medication orders on the MAR at that time. The nurse stated she faxed the resident ' s medication orders to the new pharmacy and since it was an order for a solutab the pharmacy did not enter it into the resident ' s MAR. The nurse stated later she and the facility realized it was her responsibility to enter this type of order on the resident's MAR. During an interview on August 5, 2022, at 11:11 a.m., RN-E stated she discovered R1 was not on the scheduled morphine dosage was ordered by the provider after talking to the home health aide during an onsite visit on March 1, 2022. The licensee's Medication & Treatment Orders policy dated July 2021, indicated an RN, LPN, therapist, or person at Encore who is qualified to receive orders will obtain all medications and treatment orders in writing, verbally, or electronically by an authorized prescriber. Also, the policy indicated upon receipt of medication and/or treatment order, whether new or change of an order from an authorized prescriber, a licensed nurse must take action to implement the order within 24 hours. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 6 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews, and document review, the facility failed to ensure one of one (R1)residents/clients reviewed (C1/R1) was free from maltreatment. R1/C1 was abused/neglected/financial exploited. Findings include: The Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that the an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility.	02360	No plan of correction required for tag 2360. Please refer to the public maltreatment report for details.	