Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303538584M
Compliance #: HL303535967C

Date Concluded: January 11, 2024

Name, Address, and County of Licensee Investigated:
The Encore at Hugo
5607 150th Street North
Hugo, MN 55038
Washington County

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

Evaluator's Name: James P. 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): An unlicensed staff member/alleged perpetrator (AP) abused the resident when the AP reprimanded and restrained the resident for being uncooperative.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Although an altercation occurred between the resident and the staff member/alleged perpetrator (AP), it is unable to be determined if abuse occurred as conflicting accounts of the incident were provided.

The investigator conducted interviews with members of the facility nursing staff, agency staff personnel, and the resident's family. The investigation included review of the resident's medical record, facility staffing schedules, personnel files, policies and procedures, grievances, and incident reports. At the time of the onsite visit, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living facility memory care unit. The resident's diagnoses included Alzheimer's disease, cognitive communication deficits, and major depressive disorder. The resident's service plan included medication administration, assistance with activities of daily living, and housekeeping.

According to complaint documents, an incident occurred during the night shift between the resident and the AP. The AP was overheard yelling at the resident and restrained the resident by locking the resident's wheelchair brakes, before forcefully pushing the resident back to their room.

The next morning the incident was reported to facility management. Facility management placed the AP on administrative leave and initiated an internal investigation. During the internal investigation, the AP denied abusing the resident, however, the AP's employment was terminated as a result of the investigation.

No video camera footage was available to review from the night of the alleged incident.

During an interview, a staff member who worked the night of the incident stated the AP appeared visibly upset and used a loud and angry tone of voice with the resident. The staff member stated that on two occasions that night, it appeared the AP restrained the resident when the AP locked the resident's wheelchair brakes to restrict the resident's movement.

During an interview with a nurse at the facility, the nurse indicated she was informed of the incident the following morning and initiated an internal investigation. The nurse indicated the resident was assessed that morning and had no visible injury but confirmed the AP was terminated after completion of the internal investigation.

During an interview, the AP admitted to using a loud tone of voice but denied restraining or verbally abusing the resident.

During an interview with the resident's family member, they stated the facility kept them well informed of the incident and they had no further concerns with the care or treatment provided by facility staff.

At the time of the onsite visit, the resident was not available for interview.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(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; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Unavailable for interview.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: The facility immediately removed the AP from the schedule, completed an internal investigation, and reported the incident. The AP is no longer employed at the facility.

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

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
	30353	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCORE AT HUGO	5607 150TH STREET NORTH HUGO, MN 55038

(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 ASSISTED LIVING PROVIDER 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: #HL303535967C/#HL303538584M On December 18, 2023, 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 15 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL303535967C/#HL303538584M tag identification 0620 and 2380.	0 000	The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. Minnesota Department of Health is documenting the State 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.	

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0 000	Continued From page 1	0 000	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.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (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	0 620		

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0 620	Continued From page 2 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 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 an allegation of suspected abuse to Minnesota Adult Abuse Reporting Center (MARRC) within 24 hours of staff becoming aware of the incident for one of one resident (R1). 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	0 620		

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0 620	Continued From page 3 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). Findings include: R1's record was reviewed. R1's diagnoses included Alzheimer's disease, cognitive communication deficit, and major depressive disorder with occasional confusion, and some difficulty recalling details. The resident's service plan, dated February 2, 2023, directed staff to provide assistance with medication administration, assistance with activities of daily living, and housekeeping. Review of a facility incident report dated September 8, 2023, indicated R1 was abused when an unlicensed personnel (ULP-C) was witnessed on two occasions using R1's wheelchair as a restraint by locking the brake mechanism and using a loud tone of voice to reprimand her while dragging R1 who was still seated in the locked wheelchair back to her room. During interview on December 18, 2023, Associate Administrator (AD)-D stated that while working as a caretaker on the overnight shift, loud voices could be heard from the other side of the floor. When she arrived, she observed the interaction between the AP and R1. She intervened and attempted to deescalate by assuming care of R1. As R1 continued to wheel out to the dining area, ULP-C became increasingly upset with R1. ULP-C used R1's wheelchair as a restraint by locking the brake mechanism and used a loud tone of voice to	0 620		

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0 620	Continued From page 4 reprimand R1 while dragging R1, who was still seated in the locked wheelchair, back to her room. During interview on December 18, 2023, Licensed Practical Nurse (LPN)-B stated she initiated an internal investigation after AD-D reported the incident to her on September 8, 2023. The facility did not submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) about the incident until seven days later on September 15, 2023. Attempts were made to interview R1 but she was not available for comment. The facility's complaint Grievance policy dated July 2021, indicated In a case where maltreatment was identified (abuse, neglect, or exploitation), a staff of Encore will promptly contact the Minnesota Adult Abuse Reporting Center (MAARC) to make a report. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
02380 SS=D	144G.91 Subd. 10 Individual autonomy Residents have the right to individual autonomy, initiative, and independence in making life choices, including establishing a daily schedule and choosing with whom to interact. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to respect a resident's individual autonomy and choices by not allowing the resident the right to choose their own schedule,	02380		

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02380	Continued From page 5 routine, and location of preference within the facility for one of one resident (R1). 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). Findings include: R1's record was reviewed. R1's diagnoses included Alzheimer's disease, cognitive communication deficit and major depressive disorder with occasional confusion and some difficulty recalling details. R1's service plan dated February 16, 2023 directed staff to provide assistance with medication administration, assistance with activities of daily living, and housekeeping. Review of a facility incident report dated September 8, 2023, indicated an unlicensed personnel (ULP-C) was witnessed on two occasions using R1's wheelchair as a restraint by appearing to activate the brake mechanism and using a loud tone of voice to reprimand R1, while dragging R1 who was still seated in the locked wheelchair back to her room. ULP-C also demanded R1 to go to back to her room and refused to allow R1 to remain in the dining room. During interview on December 18, 2023 Associate Administrator (AD)-D stated that while working as a caretaker on the overnight shift, loud	02380		

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02380	Continued From page 6 voices could be heard from the other side of the floor. When AD-D arrived in the common area, she observed the interaction between ULP-C and R1. She intervened and attempted to deescalate by assuming care of R1. AD-D then took R1 to use the restroom in her room when ULP-C again entered the room and continued to use a loud or aggressive voice stating R1 did not need to use the bathroom as ULP-C had just assisted R1 to the bathroom. During interview on December 18, 2023, ULP-C denied the use of a loud or aggressive voice or locking the resident in place using the wheelchair as a restraint. During interview on December 18, 2023, Licensed Practical Nurse (LPN)-B stated she initiated an internal investigation into the incident after AD-D reported the incident to her on September 8, 2023. LPN-B acknowledged ULP-C was terminated following completion of the investigation. The facility's Resident Bill of Rights indicated all residents have the right to individual autonomy, initiative, and independence in making life choices and establishing a daily schedule. TIME PERIOD FOR CORRECTION: Seven (7) days	02380		