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 #: HL283536966M
Compliance #: HL283533325C

Date Concluded: October 6, 2023

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: Deb Schillinger 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 alleged perpetrator (AP) abused the resident when the AP repeatedly yelled, cursed, and her swung arms in front of the resident in an intimidating and threatening manner.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. While there was conflicting information regarding the interaction and it may have been discourteous, it did not result in abuse. The AP later apologized to the resident who accepted the apology.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of resident records, employee records, the facility's policies, incident reports, police report and observations of interactions between residents and facility staff.

The resident resided in an assisted living facility. The resident's diagnoses included mild cognitive impairment and congestive heart failure. The resident's service plan indicated the

resident required assistance with medication management, dressing, grooming, and resident required assistive devices for mobility. The resident's assessment indicated mild memory impairment requiring reminders, but resident was able to communicate effectively and make her needs known.

A facility discipline report indicated a police officer notified the facility of a MAARC report made regarding an incident two days prior where the resident was upset after an interaction with the AP. The report indicated the AP was given a written warning and provided additional education on courteous care by facility wellness director. The wellness director stated there were no other incidences of concern for the unlicensed caregiver brought to her attention.

The investigation report from the facility nurse indicated the resident reported the AP used a "rough voice" responding to her but did not make threatening body movements. The report also indicated the resident denied feeling threatened during the interaction or unsafe after the incident.

When interviewed, the nurse stated she investigated the incident, and the unlicensed caregiver was issued a written warning for inconsiderate care of a resident.

When interviewed the AP stated she was working alone during a busy time. She stated the resident was raising her voice and insistent on having her walker brought back to her room. The AP admits feeling rushed and unable to complete the requested task at that time. She admitted to talking to the resident with a loud tone of voice but denied using curse words or swinging arms in a threatening manner.

The resident's family member stated that the resident immediately following the incident was not afraid or threatened by AP, but resident was upset because AP felt her needs were not important and the unlicensed caregiver seemed more concerned with cleaning the dining area. The family member stated the resident relayed to her the AP apologized after the incident and the resident was satisfied.

During an interview with the resident, the resident stated she could vaguely remember an incident but could not remember any other details. The resident stated no concerns with staff and felt safe at facility since the incident.

In conclusion, the Minnesota Department of Health determined abuse 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.

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.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility nurse completed an investigation and provided re-education to the AP.

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
	28353	A. BUILDING: _____ B. WING _____	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 On August 15, 2023 the Minnesota Department of Health initiated an investigation of complaint #HL283533325C/#HL283536966M. No correction orders are issued.	0 000		