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 #:** HL306087966M
**Compliance #:** HL306084918C

**Date Concluded:** March 27, 2024

**Name, Address, and County of Licensee Investigated:**
The Encore at North Branch
38610 14th Avenue,
North Branch, MN 55056
Chisago County

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

**Evaluator's Name:** Brandon Martfeld, 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 staff neglected the resident when they failed to identify a change in the resident's condition and send the resident to the hospital.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was not substantiated. Facility staff notified the on-call nurse of the resident's change in condition. Another nurse that came to the facility the following day to complete the resident's catheter change noticed further changes with the resident's condition and sent the resident 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, hospital records, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and generalized weakness. The resident's service plan included assistance with dressing, toileting, catheter care, and bathing. The resident required assist of one staff to walk with a walker and had severe cognitive impairment.

A progress note indicated one morning, the resident was sent to the hospital because of right sided weakness and facial drooping.

The hospital record indicated the resident was admitted to the hospital with myxedema coma (caused by a severely underacting thyroid gland causing decreased mental status, low body temperature, and other symptoms related to slowing of function in multiple organs), low blood pressure, and a slow heart rate. At the hospital, the resident did not respond understandably, and would mumble unintelligible words. A treatment plan was discussed with the family who decided to provide comfort care for the resident.

The resident's death record indicated the resident passed away one day after returning to the facility from the hospital. The resident's cause of death was myxedema coma and hypothyroidism (underacting thyroid gland).

During an interview, unlicensed personnel stated the day before the resident was sent to the hospital, he was not himself, he was in bed and was sleepy. The ULP stated the nurse was notified of the resident's change and directed staff to continue to monitor the resident's condition.

During an interview, another unlicensed personnel stated she worked the evening before the resident was sent to the hospital. The ULP stated she received report that the resident was tired, and the on-call nurse had been notified. The ULP stated when she first started her shift, she visited with the resident. The resident was lying in bed and talking. The resident received a shower and ate dinner in the dining room the evening before going to the hospital. The resident did not report anything about not feeling well.

During an interview, licensed practical nurse (LPN) stated she arrived early morning to change the resident's catheter. The LPN stated she observed the resident with right sided facial drooping and right sided weakness. The LPN stated when she asked staff about the resident's condition, the staff said they noticed a change with the resident the day before and notified the on-call nurse. The LPN stated the resident was very likely having a stroke. The LPN stated she completed a set of vital signs (blood pressure, pulse, and oxygen levels) that were within normal range. The LPN stated she contacted the resident's family member and the family member agreed to send the resident to the hospital.

During an interview, leadership stated the staff knew the resident was not feeling well and notified the on-call nurse. Early morning the next day, a LPN came into the facility to change the

resident's catheter. The LPN sent the resident to the hospital. The resident came back to the facility on hospice and passed away the next day.

During an interview, the family member stated the resident was trying to dance with facility staff two days before going to the hospital. The family member stated she had no concerns with the care provided at the facility, and she was notified whenever the facility had concerns with the resident.

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**: Yes.
**Alleged Perpetrator interviewed**: Not Applicable.

**Action taken by facility:**
The on-call nurse was notified of resident's symptoms, and the resident was sent to the hospital.

**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 |
|---|---|---|---|
| | 30608 | A. BUILDING: _____ B. WING _____ | C 02/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ENCORE AT NORTH BRANCH | 38610 14TH AVENUE NORTH BRANCH, MN 55056 |

| (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 |
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| 0 000 | Initial Comments<br><br>On February 21, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL306084918C/#HL306087966M. No correction orders are issued. | 0 000 | | |