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 #:** HL306881701M
**Compliance #:** HL306883249C

**Date Concluded:** June 4, 2023

**Name, Address, and County of Licensee Investigated:**
Epiphany Assisted Living
10955 Hanson Blvd NW
Coon Rapids, MN 55433
Anoka County

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

**Evaluator's Name:** Yolanda Dawson, RN
Special Investigator

**Finding:** Inconclusive

**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 a resident when the resident presented with bruising of unknown origin to her face and arm and no explanation was provided.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was inconclusive. Although the resident had suspicious bruises, the resident did not know how the bruising occurred and the facility investigation could not determine the origin of the resident's bruises.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted hospice care and a family member. The investigation included review of resident facility and hospice records, employee records and facility policies and procedures. Also, the investigator observed a staff member providing assistances with activities of daily living.

The resident resided in an assisted living memory care unit. The resident's diagnoses included a chronic obstructive pulmonary disease, emphysema, Alzheimer's disease, dementia with behavioral disturbance, and anxiety. The resident also received hospice care. The resident's service plan included staff assistance with transfers and with all cares and activities of daily living. The resident's assessment indicated the resident was vulnerable to abuse by others and unable to report abuse or neglect due to cognitive deficits and memory loss.

One morning a staff member reported to the nurse the resident had bruises on her face and arm. The nurse assessed the resident and found bruises on the residents chin, right forearm, and right cheek with redness under the eye. The resident was unaware of the bruises and was unable to provide information regarding the origin of the bruises.

Review of the facility's investigation indicated there were no reports of resident incidents including falling. The use and safety of assistive devices were reviewed, and no issues were found. Interviews with staff members did not reveal an origin of the residents bruising.

The hospice nurse documented the director of nursing (DON) informed her of the resident's bruises of unknown origin. The hospice nurse assessed the resident the same day of the report and found bruising on the right inner and outer forearm, right cheek, and middle chin. It was also noted the DON reported scattered scratches on the resident's body.

During an interview, a staff member stated she reported to the nurse a bruise on the resident's hand. The staff member stated she did not know how the resident got the bruise and had not witnessed any staff member being rough with the resident,

During an interview, the nurse stated the resident had a recent decline in her health status and was increasingly fragile. The nurse stated the resident favored her right side which was the side the bruises were on. The nurse stated the facility investigation indicated variables that could have led to the bruising including the resident leaning or rolling into the siderails, fragile skin that was susceptible to bruising, and irregular lab values.

During an interview, a family member stated he did not have concerns regarding the resident's care at the facility. The family member stated they were made aware of the resident's bruises and the facility was looking into how the bruises occurred.

In conclusion, the Minnesota Department of Health determined neglect 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.

**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, deceased.
**Family/Responsible Party interviewed**: Yes
**Alleged Perpetrator interviewed**: Not Applicable

**Action taken by facility:** Internal investigation conducted. Review of vulnerability assessment and a plan for staff education.

**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 |
|---|---|---|---|
| | 30688 | A. BUILDING: _____ B. WING _____ | C 02/16/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EPIPHANY ASSISTED LIVING LLC | 10955 HANSON BOULEVARD NW COON RAPIDS, MN 55433 |

| (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 16, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL306883249C/#HL306881701M. No correction orders are issued. | 0 000 | | |