Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306099062M
Compliance #: HL306092571C

Date Concluded: April 3, 2026

Name, Address, and County of Licensee Investigated:
The Encore at Champlin
11469 Jefferson Court
Champlin, MN 55316
Hennepin County

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

Evaluator's Name: James Larson, 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 facility neglected the resident when staff failed to implement additional supervision and fall precautions after the resident had fallen. The resident fell again and required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell on more than one occasion and sustained injury, there was not a preponderance of evidence to support that the falls were a result of staff's failure to provide necessary care or services.

The investigator conducted interviews with facility staff members, including nursing staff. The investigation included review of the resident record(s), death record, hospital records, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed staff interactions and care provided to the residents.

The resident resided in an assisted living facility. The resident's diagnoses included Hypotension, (low blood pressure), respiratory failure, chronic obstructive pulmonary disease (COPD). The resident's service plan included assistance with medication management and activities of daily living. The resident's assessment indicated she overestimated her abilities to care for herself and her situations at times.

The resident's medical record indicated on morning while the resident was alone in the bathroom she lost her balance and scraped her arm resulting in a skin tear. The resident self-reported this to the facility nurse who assessed the resident and dressed the wound. Days later, the resident complained of increased pain in her shoulder. The facility contacted the resident's primary care provider who ordered x-rays which revealed a fracture of the collar bone as well as multiple ribs. It was determined that the resident would benefit from the addition of hospice services for further pain management without surgical intervention. Weeks later, the resident sustained another unwitnessed fall during the night in her apartment resulting in a fractured hip and was transported to a local hospital. The resident passed away later that same day.

During an interview, a nurse stated after the results of the mobile rays revealed additional injuries to the resident's rib cage and clavicle, the facility urged the resident to seek treatment and evaluation at a local hospital. The resident and her family declined and instead chose to collaborate with the facility and primary physician, choosing to not pursue treatment options outside of the facility. The care plan was updated to include the addition of Hospice care for further pain management and the need for additional services for the resident which included increased wellness checks. The resident remained active at the facility and returned to her baseline status. On the night of the fall that resulted in hip injury, the resident reported to the nurse that she had gotten out of bed independently and fell.

During an interview, a family member stated that the facility nurse notified him of the falls promptly and worked closely with him in developing a plan of care. He had no other concern with the care or treatment the resident received at the facility.

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, Deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility documented, assessed, and evaluated the resident's care plan as well as coordinating hospice care as needed.

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
	30609	A. BUILDING: _____ B. WING _____	C 03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCORE AT CHAMPLIN	11469 JEFFERSON COURT NORTH CHAMPLIN, MN 55316

(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 March 9, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL306092571C/#HL306099062M. No correction orders are issued.	0 000		