

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL206193588M
Compliance #: HL206193142C

Date Concluded: September 21, 2026

Name, Address, and County of Licensee

Investigated:

Ridgeview Senior Living
1009 10th Ave NE 14
Sauk Rapids, MN 56379-9448
Benton County

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

Evaluator's Name:

Erin Johnson-Crosby, RN Special Investigator
Heather Beigel, 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 an antipsychotic medication was given after the resident's medical power of attorney requested that the medication be held. The resident was given the medication for thirteen days causing catatonia and psychosis which resulted in hospitalization.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The facility placed the medication on hold due to family request. The medication was taken off hold by an on-call staff. Upon discovery of the error, licensed staff contacted the physician. There was not a preponderance of evidence indicating the facility neglected the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted Hospice care. The investigation included review of the resident records, hospital records, pharmacy records, facility internal investigation, facility incident reports, staff schedules, related facility policy and procedures. Also, the investigator observed medication administration and interaction between staff and residents.

The resident resided in an assisted living memory care unit and received hospice care. The residents' diagnoses include dementia, depression, catatonia (frozen or unresponsive) and multiple sclerosis. The resident's service plan included assistance with medication administration and cares of daily living. The resident's assessment indicated the resident had severe cognitive impairment, anxiety, delusions and hallucinations. The resident was resistive to cares, required assistance for dressing, grooming, mobility and assistance for transfers.

Facility documentation indicated the family reported the resident had increased confusion and was not able to feed herself. A family member asked an unlicensed staff what medications the resident received the evening prior. The resident's family noticed the anti-psychotic medication had been given to the resident.

An incident report indicated an anti-psychotic was ordered by the resident's physician and put on hold by family on the same day. The nurse placed the medication on hold per family request but there was no documentation indicating the nurse requested a hold order from the provider.

Twenty days later an unlicensed staff found the medication in the medication cart, saw it was on hold and called the after-hours nurse to ask if the medication should be given. The on-call nurse noticed the medication was on hold waiting for prior authorization (approval for payment). The on-call nurse took the medication off hold, instructed the ULP to administer the medication. The family and facility were not aware that the medication was taken off hold and administered to residents for 13 days. When the medication error was discovered, the facility nurse reported it to the physician and the medication was discontinued.

Five days later the resident was hospitalized for catatonia symptoms. The resident has had previous hospitalizations for catatonia. The resident spent six days in the hospital and returned to the facility.

During an interview, a nurse stated the antipsychotic medication was placed on hold per family request and did not know if the physician was notified of the hold order. The nurse was not aware the medication was taken off hold until she was informed by the resident's family member.

During an interview, the on-call nurse stated she received a call from an unlicensed staff informing her the medication Olanzapine was in the cart but was on hold. The nurse reviewed the progress notes and the order and noticed the antipsychotic medication was put on hold due

to the need for prior authorization. The nurse took the medication off hold, and instructed staff to administer the medication.

During the interview, family members stated one morning the resident woke up slurring her words, could not feed herself, and didn't know what a spoon was for. The resident just started on Gabapentin for her high anxiety. A family member went to the medication cart and noticed the resident had been receiving the antipsychotic medication which family requested be held. The family member went to the nurse and was told that the medication had been taken off hold and that the resident had received 13 doses. The resident became catatonic and was hospitalized.

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, due to cognition

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

The facility investigated the incident.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20619	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/12/2026
NAME OF PROVIDER OR SUPPLIER RIDGEVIEW SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1009 10TH AVENUE NE SAINT JOSEPH, MN 56374			
(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 12, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL206193142C/#HL206193588M. No correction orders are issued.	0 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE