

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL206196328M
Compliance #: HL206199568C

Date Concluded: February 24, 2025

Name, Address, and County of Licensee

Investigated:

Ridgeview Senior Living
1009 10th Avenue NE
Sauk Rapids, MN 56379
Benton County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 supervision was not provided in accordance with the resident's service plan. The resident was left unattended in the bathroom when she fell, requiring her to be evaluated in the emergency room.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to reassess the resident after she began requiring additional assistance with transfers and required the use of a wheelchair for mobility. Facility staff noted a brake on the wheelchair was not locking properly but continued to use the wheelchair. The resident tried to self-transfer out of the wheelchair and fell on the floor.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the primary care provider. The investigation included review of the resident record, hospital records, facility internal

investigation documentation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed the resident's room and location where she fell.

The resident resided in an assisted living facility. The resident's diagnoses included dementia. The resident's service plan included assistance with mobility, transfers, toileting, and activities of daily living. The resident's assessment indicated the resident used a walker and needed redirection due to being disoriented to person, place, and time.

The resident's record lacked documentation to show when she began using a wheelchair, who provided the wheelchair, or what condition the wheelchair was in. The service plan was not updated to reflect the resident using a wheelchair. An assessment was not completed to reflect the resident's change in condition when she began using a wheelchair.

The facility did not have any records related to the wheelchair being used by the resident.

The incident report indicated the resident had been set up in front of the bathroom sink in her wheelchair with brakes on for independent grooming. When staff returned, the resident was on the floor next to the cupboard, with the wheelchair "located with brakes on next to resident."

Hospital records indicated the resident had bruising and a laceration on her right thumb, right ankle pain, and a scalp contusion/hematoma. After evaluation in the emergency room, she was discharged back to the facility with a cam walker, a type of orthopedic boot.

During an interview, an unlicensed personnel (ULP) working the day the resident fell, stated she helped get the resident up and ready and the resident only required set-up assistance. Another resident called for assistance so the ULP left the room to answer the call light and asked a housekeeper to go check on the resident in a few minutes. The ULP stated the housekeeper later called on the walkie talkie for her to return to the room as the resident had fallen. The ULP stated the resident's care plan at that time did not require staff to stay with her at all times. The ULP stated the resident was using a wheelchair provided by the facility and that staff had told facility management that the locks on the wheelchair didn't lock. The ULP stated they were told by management they were going to get the wheelchair fixed or find another one, but it was "too little, too late" and it never got fixed.

During an interview, another ULP working the day the resident fell, stated the resident's care plan did not require anyone to stay with her in the bathroom at the time she fell. The ULP stated she was called into the room after the resident fell and was told the resident was alone in the bathroom at the time of the fall. The ULP stated the resident had been using a facility wheelchair and it was "not in good condition." The ULP stated one brake was not working and people had talked to management about it, but nothing got fixed. The ULP stated there was some turnover with management around the time concerns were brought forward so that may have been why it was never addressed.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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:

No action taken.

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities
Benton County Attorney
Sauk Rapids City Attorney
Sauk Rapids Police Department

Minnesota Department of Health

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| 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 02/03/2025 |
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| NAME OF PROVIDER OR SUPPLIER RIDGEVIEW SENIOR LIVING | STREET ADDRESS, CITY, STATE, ZIP CODE 1009 10TH AVENUE NE SAUK RAPIDS, MN 56379 |
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| (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 | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>#HL206196328M/ #HL206199568C</p> <p>On February 3, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 57 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for #HL206196328M/ #HL206199568C, tag identification 2360.</p> | 0 000 | <p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p> | |
| 02360 | <p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>Residents have the right to be free from physical,</p> | 02360 | | |

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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| 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 02/03/2025 |
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| NAME OF PROVIDER OR SUPPLIER RIDGEVIEW SENIOR LIVING | STREET ADDRESS, CITY, STATE, ZIP CODE 1009 10TH AVENUE NE SAUK RAPIDS, MN 56379 |
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|--------------------|--|---------------|---|--------------------|
| 02360 | <p>Continued From page 1</p> <p>sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p> | 02360 | No plan of correction is required for this tag. | |