Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL206198684M
Compliance #: HL206196106C

Date Concluded: January 18, 2024

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: Erin Johnson-Crosby, 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 the resident when the resident experienced a change in condition and was left in the dining room all day. The facility did not notify a registered nurse or emergency services.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. It was unable to be determined if neglect occurred. Facility staff interviewed could not recall details of the incident and documentation available provided no evidence of an observed change in the resident's condition. When the resident's family reported a concern with a change in the resident's behavior, facility staff contacted emergency medical services (EMS) per the family's request and the resident was transported to the hospital for further evaluation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident, facility, and hospital records.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia with behavioral disturbance, coronary artery disease, and a heart murmur. The resident's service plan included assistance with dressing, grooming, safety checks, medication administration, and escort assistance to meals. The resident's assessment indicated the resident had a history of agitation and resistance towards care. The assessment indicated the resident was independent with transfers and walking.

The resident's medical record indicated the resident was transferred out of the facility via ambulance. The medical record indicated a family member reported to staff the resident was not acting normal and requested EMS be contacted. Facility staff contacted EMS per the family's request, then contacted the nurse to report the incident.

Review of staff documentation from the day of the incident included no additional notes detailing a change in the resident's condition. Staff documented the resident received assistance with morning cares and an escort to breakfast. Staff also documented the resident was checked on at 10:00 a.m., refused toileting assistance at 11:00 a.m., and was escorted to the noon meal.

The resident's Medication Administration Record (MAR) from the day of the incident indicated the resident's 8:00 a.m. and 2:00 p.m. medications were "held" and not administered. The medication notes section did not specify why the scheduled medications were not administered.

Video surveillance from the day of the incident displayed a staff member assisted the resident to the dining room at 8:09 a.m. The video showed the staff member take the resident by the hands to guide the resident into the dining room; it appeared the resident had difficulty lifting her right leg. The video showed staff enter and exit the dining room multiple times throughout the video. The video did not show the resident leave the dining room area after breakfast; however, a bathroom was located near the dining room that was not visible by the camera. At 4:21 p.m., the resident's family member was seen assisting the resident out of the dining room. The resident appeared to walk without difficulty. A short time later, the ambulance crew arrived and took the resident to the hospital.

The hospital records indicated the resident was admitted for generalized and right leg weakness. The initial computerized tomography (CT) scan (imaging) of the head was negative. The next day a magnetic resonance imaging (MRI) was completed and revealed evidence of an acute stroke. The resident did not receive antithrombotic (to prevent or reduce the formation of blood clots) medications as the resident was outside the therapeutic window and was at risk for bleeding. The resident was discharged to a skilled nursing facility 23 days later.

During an interview, the unlicensed personnel (ULP) assigned to administer medications the morning of the incident stated she did not know what there would have been a “H” on the resident’s MAR. The ULP stated if the resident refused the medications, it would be marked as refused. The ULP did not recall any further details of the incident.

During an interview, another ULP who worked the day of the incident stated the resident did not speak English, so communication was very difficult. The ULP was told the resident had been sitting in the dining room since the noon meal. The ULP stated she tried to get the resident to come out of the dining room, but the resident refused. The ULP checked on the resident multiple times. The ULP stated the resident appeared tired and was playing with her food. The ULP stated the resident refused toileting assistance offered at 3:00 p.m. The ULP stated it was not abnormal for the resident to sit in the same place for hours and refuse cares. The ULP stated the family member (FM) assisted the resident back to the resident’s room and had the ULP contact EMS.

During an interview, the previous clinical supervisor stated he had only worked at the facility for two months around the time of the incident and did not recall the details of the incident.

During an interview, the family member stated he arrived at the facility around 4:20 p.m. and the ULP told him the resident had been sitting at the dining room table since breakfast. The family member saw food on the floor and tears in the resident’s right eye and the resident was not able to move. The family member stated the resident was not able to move her right leg, so he had to assist her to her room. The family member instructed the ULP to call 911 because something was not right. The family member was upset that his mother was left in the dining room all day, and no one called him. The family member stated the resident suffered a severe stroke. The family member indicated they requested documentation from the facility multiple times regarding the incident but received no information.

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; unavailable for interview
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:
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
	20619	A. BUILDING: _____ B. WING _____	C 12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEVIEW SENIOR LIVING	1009 10TH AVENUE NE SAUK RAPIDS, MN 56379

(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 December 1, 2023, the Minnesota Department of Health initiated an investigation of complaint # HL206198555C and HL206196106C/#HL206198684M. No correction orders are issued.	0 000		