Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL218715182M
Compliance #: HL218711800C

Date Concluded: October 20, 2025

Name, Address, and County of Licensee Investigated:
River Oaks Columbia Heights
900 42nd Avenue Northeast
Columbia Heights, MN 55421
Anoka County

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

Evaluator's Name: Brandon Martfeld, RN, BSN, 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 the facility failed to address a change in condition. The resident had significant weight gain resulting in decreased mobility, heart health, and breathing concerns.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had gained weight continuously over six months after admitting to the facility. The facility notified the resident's primary care provider and psychiatrist. The primary care provider ordered blood tests, made referrals to outside specialists, and notified psychiatry for medication adjustments.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted the resident's primary care provider. The investigation included review of the resident records, staff schedules, and related facility policy

and procedures. Also, the investigator toured the facility and observed interactions between facility staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included attention-deficit hyperactivity disorders, depression, post-traumatic stress disorder, conversion disorder, borderline personality disorder, and anxiety. The resident's service plan included assistance with management of repetitive behaviors, medication administration, and monthly weights. The resident's assessment indicated the resident was alert, oriented and was independent with activities of daily living.

The resident's medical record indicated the resident gained 72 pounds in a four-month span. The primary care provider ordered tests and no known cause for the weight gain could be determined. The resident's medical record indicated the resident's Abilify (antipsychotic) medication was discontinued due to being a possible contributing factor for the resident's weight gain.

During an interview, leadership stated the resident's primary care provider was notified of the resident's weight gain approximately 14 days after the resident admitted to the facility. The primary care provider ordered blood tests in an attempt to find out why the resident gained weight, and the resident was started on Lasix (loop diuretic) for swelling in her legs. The resident's Abilify medication was discontinued because providers thought the medication may have been a factor in the resident's weight gain. In house providers continue to monitor the resident's weight gain.

During an interview, a primary care provider stated the resident's weight gain was a concern. Several blood tests and referrals to several specialists were made. Test results indicated it was actual weight gain and was not fluid retention related issues. The primary care provider stated weight gain is a side effect of antipsychotic medications, and the psychiatrist was notified. The psychiatrist made adjustments to the resident's antipsychotic medications.

During an interview, the resident stated it is unknown why she gained weight.

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

Action taken by facility:
The facility notified the resident's primary care provider of the resident's weight gain.

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
	21871	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS COLUMBIA HEIGHTS	900 42ND AVENUE NE COLUMBIA HEIGHTS, MN 55421

(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 October 2, 2025, the Minnesota Department of Health initiated an investigation of complaint HL218715182M/HL218711800C. No correction orders are issued.	0 000		