Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL274895861M
Compliance #: HL274898340C

Date Concluded: November 14, 2024

Name, Address, and County of Licensee Investigated:
Riverside Assisted Living
885 Meadowview Circle North
Pillager, MN 56473
Cass County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, 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 alleged perpetrator (AP), an unlicensed personnel (ULP), emotionally abused the resident when she repeatedly yelled at him saying things like "What do you want now?" "Get back to your room" and "How many times do I have to tell you?"

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The investigation found there was insufficient evidence to determine if abuse occurred. The resident was not able to be interviewed and the AP denied abusing the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, death record, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, and facility policies and procedures. Also, the investigator observed the resident's room and care and services provided at the facility.

The resident resided in an assisted living facility. The resident's service plan included assistance with dressing, grooming, bathing, medication administration, transfer assistance, and safety checks. The resident's assessment indicated the resident received hospice services and the resident had impaired cognition and confusion.

The facility's internal investigation indicated residents reported hearing the AP verbally abuse the resident. It was reported the AP was heard yelling things like "What do you want now?" "How many times do I have to tell you to stop it?" and "Get back to your room," in a loud, irritated voice. The residents reported to management that it wasn't the first time they overheard the AP raise her voice at the resident.

During an interview, facility management stated there were previous concerns with the AP's professionalism and quality of work and the AP frequently came to work looking disheveled. Facility management stated they never witnessed the AP being verbally aggressive towards residents prior to this incident. Facility management stated they investigated after they received concerns from other residents, and the AP's employment was terminated.

The resident passed away and was not available for interview.

During an interview, the AP denied yelling at the resident. The AP stated she sometimes had to talk in a louder tone of voice as some residents were hard of hearing, but she did not yell at any residents.

The resident who overheard the incident could not recall the exact details of the incident but stated she felt the AP was "owly."

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
Upon learning of the allegations, the facility investigated the incident and reported it to MAARC. The AP was terminated.

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
	27489	A. BUILDING: _____ B. WING _____	C 10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE ASSISTED LIVING	885 MEADOWVIEW CIRCLE NORTH PILLAGER, MN 56473

(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 21, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL274895861M/#HL274898340C. No correction orders are issued.	0 000		