Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL313682663M
Compliance #: HL313684481C

Date Concluded: June 12, 2023

Name, Address, and County of Licensee Investigated:
Aviva River Bend
30 Silver Lake Place NW
Rochester, MN 55901
Olmsted 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 a resident when the facility failed to assess, monitor, and implement interventions for multiple skin concerns.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The Minnesota Department of Health determined neglect was inconclusive. The facility consistently failed to document skin checks and interventions, despite the resident being at risk for skin break down due to edema and incontinence. However, due to the lack of documentation it is unknown if interventions were provided or if the physician was notified. It could not be determined if maltreatment occurred.

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

The resident resided in an assisted living facility. The resident's diagnoses included history of leukemia, anemia, and edema (swelling). The resident's service plan included assistance with activities of daily living, toileting, bathing, escorts to meals, medication administration, and application of ace wraps to lower legs.

The resident's assessment indicated the resident's skin was intact, but the resident was at risk for skin breakdown related to incontinence. The assessment did not identify lower extremity edema or application of ace wraps. The treatment and therapy plan indicated the resident did not receive any treatment or therapies.

Approximately one month prior to hospitalization, the resident's medical record indicated the resident experienced a significant change in condition and required assistance with all activities of daily living. The resident's legs were weeping (fluid leaking from legs, often due to swelling) and a dressing was placed to the weeping area. The record also indicated the resident had multiple weeks of incontinent diarrhea. The record did not include documentation of physician notification or new orders.

One week prior to hospitalization, a quarter sized area was noted on the resident's right buttocks. The resident's medical record did not include documentation of physician notification, interventions, or changes to the resident services.

The resident's Services Provided document was blank, it is unknown what cares were provided by facility staff. The resident's medication administration record (MAR) indicated staff applied ace wraps to both legs but did not identify treatments for the resident's weeping legs or buttocks wound.

Hospital records indicated the resident was sent to the hospital for weakness and failure to thrive. The records indicated the resident had a recent and fast decline in functional status and the facility was no longer able to provide the care required to meet her needs. The resident arrived in the emergency department with an unstageable pressure injury (unable to see the wound bed) on the resident's left buttocks measuring 1.5 x 1.2 x 1.8 centimeters (cm), along with multiple other skin issues including skin tears to both wrists and an open area on the resident's right lower leg.

A discharge summary completed by the facility, one week following the resident's hospitalization, indicated the resident had a right buttocks pressure ulcer, a skin tear to her right arm, and significant edema that was difficult to manage. The summary indicated the resident was incontinent throughout the day which contributed to the pressure ulcer. The summary further indicated the resident experienced a sharp decline in health status and was hospitalized.

During an interview, unlicensed personnel (ULP) recalled the resident had “leaky legs” and ace wraps had to be changed frequently. The ULP indicated she was trained on the application of ace wraps but not trained on how to care for the open areas of skin. The ULP could not recall if the resident had a pressure ulcer.

During an interview, the licensed practical nurse (LPN) stated the resident’s legs were both weeping. The LPN said the facility requested an order for ace wraps, but no orders were provided. The LPN was unaware if the physician was notified of the resident’s edema and weeping legs. The LPN also indicated the family was very involved in the resident’s care and would initiate treatments without notifying the facility. The LPN could not recall if the resident had a pressure ulcer prior to hospitalization.

During an interview, the registered nurse (RN) stated he was only aware of one time the resident’s legs were weeping. The RN said the LPN oversaw treatments and provision of direct resident care. The RN was not aware of the resident having any skin concerns. The RN stated if there were skin integrity concerns, the physician should have been notified. The RN did not know if the physician was notified regarding the resident’s change in condition or open area on the residents’ buttocks since it was not documented. The RN also indicated the resident was taken to the physician frequently by family members.

During an interview, the resident’s family member stated the resident was independent with activities of daily living until one month prior to hospitalization. The family member stated the resident had leukemia that was progressing and developed heart failure, causing the resident legs to swell. The family member stated there was no consistency or accuracy with staff wrapping the resident’s legs and was surprised the facility did not check the resident’s skin more often. The family members said the physician was aware of the resident’s leg swelling, change in condition, and pressure ulcer. The resident’s family member was trying to get the resident admitted into a higher level of care facility prior to the hospitalization. The resident’s family member thought the resident was seen by a physician approximately two weeks prior to hospitalization.

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

Action taken by facility:
None.

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
	31368	A. BUILDING: _____ B. WING _____	C 05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(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 May 9, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL313682663M/HL313684481C. No correction orders are issued.	0 000	Assisted Living Provider 144G. 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. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS	

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0 000	Continued From page 1	0 000	USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	