Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL313684202M
Compliance #: HL313688149C

Date Concluded: November 3, 2025

Name, Address, and County of Licensee Investigated:
Aviva River Bend
30 Silver Lake Pl NW
Rochester, MN 55901
Olmsted County

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

Evaluator's Name: Julie Serbus, RN
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 residents when resident #2 pushed resident #1 causing her to fall requiring hospitalization related to multiple fractures.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. Although, resident #2 did push resident #1 causing fractured bones there was no incidents prior to this one to indicate resident #2 would physically cause harm to another resident. ~~R2's service plan did include interventions~~

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members. The investigation included review of the resident's records, facility internal investigation, facility incident reports, staff schedules, related facility policy and procedures. Also, the investigator made an onsite visit to observe staff interaction with residents and memory care floor plan.

Resident #1

Resident #1 resided in an assisted living memory care unit. The resident's diagnoses included dementia. The service plan indicated resident #1 was independent with transfers, wandered within the facility but did not have a history of jeopardizing. Resident #1 was able to follow directions but did require verbal cues or short directions from staff. While walking, resident #1 required prompts or cues but did not require hands-on assistance with no history of behavioral concerns.

Resident #2

Resident #2 resided in an assisted living memory care unit. The resident's diagnoses included severe dementia with agitation. Resident #2's facility records indicated the resident is a recent admission and has documented bouts of agitation with interventions effectively used.
The service plan indicated resident #2 required prompts or cues for safety while ambulating but did not require hands on assistance. Resident #2 was alert and oriented to self only. Due to disorientation, resident #2 required frequent verbal prompts and/or direction from caregivers although there was a reported history of aggression towards others.

Incident

One evening an unlicensed caregiver heard yelling between two residents and went to resident #1's room where resident #1 was found on the floor with resident #2 present in the room. Resident #2 told the caregiver she had shoved resident #1. Resident #1, who was in lying on the floor and complaining of pain, told the caregiver resident #2 had pushed her. Resident #2 was removed from the area immediately while 911 was called to transport resident #1 to the emergency department.

Interviews

During an interview, nurse #1 stated resident #2 did not exhibit aggression towards other residents until this actual incident. Nurse stated resident #2 was verbal aggressive towards staff members and would refuse cares but did not strike out. On admission resident #2 was appropriate for admission with a service plan appropriate for cares. Caregivers did report resident #2's verbal aggression towards them and interventions were in place to address this concern. Nurse #1 stated the exact details of the incident were unknown as it was unwitnessed by any caregiver although the facility followed up promptly once the incident became known.

During an interview, nurse #2 stated resident #2 spent a lot of time out in the common area of memory care sitting in a chair. Nurse #2 stated resident #2 would mumble incoherently and was not easily understood. There had been no prior behaviors such as this. Resident #1 was not aggressive and did walk with a walker.

During an interview, the unlicensed caregiver stated on the day of the incident resident #2 was agitated and wandering nonstop in common area and in other resident rooms. Caregiver stated she kept an eye on resident as she wandered and provided redirection. Caregiver stated when providing care to other residents that day unable to be with resident #2 all the time. The

caregiver stated staff complete multiple trainings regarding handling behaviors and residents will have care planned interventions.

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: NA, deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: NA

Action taken by facility: Resident #2 was transferred from the facility the evening of the incident and did not return to the facility.

Action taken by the Minnesota Department of Health: No further action.

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 08/26/2025

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 August 25, 2025, through August 26, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL313688149C/#HL313684202M. No correction orders are issued.	0 000		