Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL318847964M
Compliance #: HL318844909C

Date Concluded: November 22, 2023

Name, Address, and County of Licensee Investigated:
River Oaks at Lake Pepin
815 North High Street
Lake City, MN 55041
Wabasha County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Deb Schillinger 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 resident when she complained of wrist pain and the facility did not seek care for the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility provided care as directed by the resident, who declined emergent care and chose to wait to seek treatment for three days until previously scheduled appointment.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's emergency guardian. The investigation included review of the resident record, facility incident reports, policies, and procedures. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included alcoholism, anxiety, and depression. The resident's service plan indicated the resident required supervision, behavior management with redirection. The resident's assessment indicated she was independent with ambulation and grooming but needed supervision with decision-making.

The facility report indicated the resident fell two times in the previous two weeks but did not report wrist pain until three days before the scheduled orthopedic appointment. The same report indicated the resident declined immediate treatment and chose to wait three days until her previously scheduled orthopedic appointment.

The orthopedic provider note indicated resident reported wrist pain and swelling after a fall. After an x-ray, it was found the wrist had been broken, a cast was placed for treatment.

During an interview, the resident stated she knew that she had hurt her wrist when she fell on the rocks while fishing. She stated she agreed to wait until scheduled orthopedic appointment and pain was managed with Tylenol and ice effectively.

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.
(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or
(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct;

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

Action taken by facility:

Facility staff investigated the incident, offered immediate treatment that was declined by resident and assured resident attended scheduled appointment.

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
	31884	A. BUILDING: _____ B. WING _____	C 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS AT LAKE PEPIN LLC	815 NORTH HIGH STREET LAKE CITY, MN 55041

(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 17, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL318844909C/#HL318847964M. No correction orders are issued.	0 000		