Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326498805M **Date Concluded:** November 26,2023
Compliance #: HL326496382C

Name, Address, and County of Licensee Investigated:
Rivers Edge Assisted Living
11 MN Ave South
Aitkin, MN 56431
Aitkin County

Facility Type: Assisted Living Facility (ALF) **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 alleged perpetrator, an unlicensed caregiver, abused the resident when she was rough with transfers, yelled, cursed, and threatened to withhold snacks from the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The unlicensed caregiver stated she did not curse, yell, or threaten to withhold snacks from the resident, nor was she intentionally rough with the resident during transfers.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical record, nursing assessments, service plans, and progress notes. The investigation included an onsite visit, observations, and interactions between the resident and facility staff.

The resident lived in an assisted living facility. The resident's diagnoses included depression, morbid obesity, diabetes, and congestive heart failure. The resident's service plan indicated the resident required assistance with showering, dressing, grooming, bed mobility, and transfers using an EZ stand (stand assist lift). The same document indicated the resident makes his own decisions and can make himself understood, but at times spoke too fast and/or garbled speech making it difficult to make himself understood. Additionally, the resident had difficulty hearing at conversational levels.

A facility incident form indicated a concern arose the AP was rough during a transfer using an EZ-stand. The same document indicated the AP started yelling at him and that the resident would get no snacks nor ice if the resident continued to yell at the AP. The same document indicated the resident and two staff members, including the AP, were interviewed but it did not include a summary of those interviews. The same document indicated the two staff members received education regarding use of the EZ-Stand.

The AP's employee file included a coaching and counseling regarding the reported incident addressing how to manage verbal communication with residents.

During an interview, the AP stated the resident verbalizes his needs and has specific requests on how cares are to be completed. The AP stated she may have become frustrated with the resident, but never cursed or threatened to withhold snacks. The AP stated the resident required an EZ-Stand lift for transfers which requires a belt to go around the resident's back for support and the loops hook onto the EZ-Stand. The caregiver stated to hook the belt you need to pull the resident forward to place the strap on the hooks and to disconnect the belt again you would need to slightly pull the resident forward to release the belt. Both acts of hooking up and unhooking the belt requires slight pulling forward and not intentional roughness.

During an interview, the resident stated no staff has yelled or cursed at him. The resident stated staff members are respectful to him and if someone did mistreat him, he would be able to report it. The resident stated he is transferred with an EZ-Stand and the strap used to hook him to the lift is one size to small and will pinch him.

During an interview, the licensed nurse stated she had spoken with the resident about the incident. The resident stated he did receive his snacks and did not hear staff swear. She stated the resident said staff members had been a little rough when the straps needed to be hooked up to the EZ-Stand.

In conclusion, the Minnesota Department of Health determined abuse 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.

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: Yes
Family/Responsible Party interviewed: No, VA is independent with decisions
Alleged Perpetrator interviewed: Yes

Action taken by facility:
No action taken.

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
	32649	A. BUILDING: _____ B. WING _____	C 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE ASSISTED LIVING	11 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL326496382C/HL326498805M HL326496489C/HL326498965M On October 16, 2023, through October 18, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 33 residents receiving services under the provider's Comprehensive Assisted Living license No correction orders are issued for HL326496382C/HL326498805M. The following correction order is issuedL326496489C/#HL326498965M, tag identification 2310 and 2360.	0 000	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 License Providers. 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 surveyors' 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 used f	
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure facility services were provided using a service plan subject to accepted health care standards for one of three residents (R2). The facility used an EZ stand (stand assist device) to transfer, which was not maintained according to manufacturer instructions and was missing a safety latch which led to R2 to fall during a transfer. Additionally, the facility failed to use the correct sized sling with the EZ stand which caused the resident discomfort during transfers. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 admitted to the facility on February 6, 2023, with diagnoses which included morbid obesity, depression, diabetes mellitus type 2, and congestive heart failure. R2's admission assessment dated February 7, 2023, indicated R2 needed adaptive equipment	02310		

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02310	Continued From page 2 for transfer and a wheelchair for mobility. R2's Individual Abuse Prevention Plan (IAPP) dated February 7, 2023, indicated R2 was non-ambulatory and required a wheelchair. An incident reported dated September 28, 2023, at 1:00 p.m., indicated that approximately six months beforehand facility staff member(s) transferred R2 with the EZ stand from bed to wheelchair when the sling slipped from the machine and fell to the floor with R2 landing on his right side. The report indicated the nurse was notified, checked R2 for injuries, and a Hoyer lift was used to transfer resident from floor to bed. This same document indicated the EZ stand was missing a safety latch on the side that had released. Review of facility incident forms and medical records for R2 indicated no documentation had been completed and it was not until September 28, 2023, at 1 p.m. when a incident report was completed for fall from the EZ stand when transferring which occurred approximately the week of February 20, 2023. Review of facility incident forms for R2, indicated no documentation or incident report was completed for incident when resident slide out of the EZ stand sometime in March of 2023. The resident's assesment dated February 7, 2023, completed by ALDIR-D when she was employed as a registered nusre by the facilty, indicated the resident required an EZ stand for transfers but did not specifiy the number of staff members required. The resident's assessment dated February 26,	02310		

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02310	Continued From page 3 2023, completed by ALDIR-D when she was employed as a registered nurse by the facility, indicated the resident required an EZ stand for transfers but again did not specifiy the number of staff members required. The same document indicated the interventions for falls prevention included a pendant to call for help, wheelchair for mobility, and mechanical lift (EZ stand) for transferring. An observation on October 17, 2023, at 11:05 a.m., licensed practical nurse (LPN)-B and unlicensed staff (ULP)-H transferred R2 from bed to wheelchair using the EZ Stand and a medium-size sling. The medium sling was squeezing skin together near R2's upper chest and upper abdomen requiring the staff to pull on the sling belt, with more than minimal handling, in order to clasp the belt. During an interview on October 17, 2023, at 12:57 p.m., R2 stated he requires a wheelchair at all times and an EZ Stand for transfers. R2 stated when he was transported to the facility from the hospital, he was in a wheelchair either from the hospital or the transport company. R2 stated he did not have his own wheelchair and upon arrival to the facility a wheelchair was not available for him. R2 remained in the larger wheelchair that he was transported in, but the wheelchair was too large to fit through his apartment door. R2 stated it took a while for the facility to get a wheelchair for him. R2 stated the EZ stand was owned by the facility and is not his own personal equipment. R2 stated one time during a transfer the strap slid off the EZ Stand causing R2 to drop to the floor. R2 stated a latch was missing on the EZ Stand which is needed to keep the strap from sliding off the lift arm. R2 further stated the sling used to hook him up to the EZ Stand is one size too small	02310		

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02310	Continued From page 4 and pinches his skin during transfers. During an interview on October 16, 2023, at 12:45 p.m., assisted living director in residency (ALDIR)-D stated when R2 fell out of the EZ Stand a report was not completed as ALDIR-D understand the ULP who witnessed the fall would complete a report. During an interview on October 17, 2023, at 12:02 p.m., registered nurse (RN)-A stated the sling size for weight does not take into account the girth of the resident and would require the next size up. During an interview on October 17, 2023, at 3:00 p.m., assisted living director in residence (ALDIR)-D, who is also a registered nurse, indicated a pre-admission assessment was conducted over the phone. ALDIR-D stated the facility did not have a wheelchair for R2 when he arrived and had to order one. ALDIR-D stated she was the first person to transfer and assess R2 on admission, but indicated she did not document her assessment of the transfer. ALDIR-D stated she called medical equipment to order a new wheelchair that would accommodate R2's size and that would fit through the apartment doorway. ALDIR-D stated the durable medical equipment provider did not come to the facility physically to assess R2 but requested measurements via phone. ALDIR-D stated it took four to six weeks for the wheelchair to arrive. ALDIR-D stated the EZ Stand is owned by the facility. ALDIR-D stated there were no maintenance logs available or working orders to show equipment owned by the facility was properly maintained. ALDIR-D stated she was not aware the missing safety clamp located on the arm of the EZ Stand which is required to	02310		

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02310	Continued From page 5 prevent the sling from sliding off during a transferring. ALDIR-D stated the size harness/sling that is used with the EZ Stand to transfer the resident was the correct size as the sling according to weight. ALDIR-D stated she used the weight of R2 provided by the hospital rather than obtain a weight on facility admission and used the medium size sling provided by the facility based on recommended weight limits rather than take into consideration the resident's size. The EZ Way, Inc. manual, dated December 27, 2019, indicated the stand requires a minimum of servicing to keep the equipment in good working order. The same document indicated there were basic checks to be completed periodically by a maintenance staff to ensure on-going safety throughout the life of the device. One of the safety checks included ensuring safety needs are the lift are installed correctly, not missing, or torn. The EZ Way Smart Stand Operator's Instructions manual, revised June 14, 2023, indicated EZ Way harnesses are designed to be applied or removed with a minimum amount of handling of the patient. As patients do vary in size, shape, and weight, these conditions must be taken into consideration when deciding the size of the EZ Way harness as there are a variety of sizes available. The licensee Assessment Regarding Safe Use of Assistive Devices Policy, not dated, indicated the facility will promote the safe use of assistive devices through individualized client assessments and follow-up. The licensee 6.01 Assessments, Reviews &	02310		

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02310	Continued From page 6 Monitoring policy dated August 1, 2021, indicated resident monitoring and review must be conducted as needed based on changes in the needs of the resident. TIME PERIOD FOR CORRECTION: Seven (7) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R2) was free from maltreatment. R2 was neglected. Findings include: On December 5, 2023, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		