Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL342996945M
Compliance #: HL342991491C

Date Concluded: February 3, 2025

Name, Address, and County of Licensee Investigated:
River Oaks at Watertown
409 Jefferson Ave SW
Watertown, MN 55388
Carver County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lena Gangestad, 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 the resident's oxygen tank was not filled, and the oxygen compressor was broken. Also, the resident's wound was not being care for properly lead from amputation infection.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident did not consistently use her supplemental oxygen, the equipment was observed during the investigation and found to be function properly. The resident did require hospitalization for a surgical revision of her left below the knee amputation and was treated for an infection, the facility had taken appropriate steps to coordinate her wound care with the wound clinic.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, staff schedules, policies, and procedures.

The resident lived in an assisted living facility and had a medical history that included chronic obstructive pulmonary disease (COPD) and diabetic neuropathy. Her care plan required assistance from two caregivers for all transfers, utilizing a ceiling lift to move her in and out of bed. The resident's medical history included a recent left below the knee amputation in the context of peripheral arterial disease.

The care plan indicated the resident's history of noncompliance with medical care, frequent hospitalizations, poor decision-making, and instances of leaving the facility against medical advice. Additionally, it noted that the resident was a chronic smoker.

The physician's order indicated the resident was required to wear oxygen continuously at 3 liters per minute (LPM). Hospital records indicated that the resident was no longer permitted to carry cigarettes or a vape pen due to the safety risks of using these items around oxygen.

In an email exchange, the facility manager indicated the resident was expected to wear oxygen continuously. However, the manager the resident was noncompliant with the physician's recommendations. While the resident wore oxygen at night, her usage during the day was intermittent because she frequently went outside to smoke.

During an interview, unlicensed caregiver #1 stated she was aware that the resident needed to be on oxygen continuously, but observed that the resident's oxygen was not plugged in. She also said that the resident's wound appeared clean and in good condition the last time she saw her, and she was unsure why the resident had been hospitalized.

During an interview, unlicensed caregiver #2 stated that a home health nurse visited three times a week to care for the resident's wound on her amputated leg. The nurse managed the wound vac and addressed any issues, such as leakage.

During an interview, a nurse at the facility stated that the resident had a wound vac and that a wound care nurse visited three times a week to provide treatment. The nurse said that the facility did not provide care for the wound vac, as the home health nurse managed it.

Regarding the resident left below the knee amputation wound, the facility arranged wound clinic visits for management of her stump incision. When the resident's stiches were removed, it was found one part of the wound was not healing as expected and the resident was transferred to the hospital for debridement of the stump wound.

The hospital records indicated the resident was diagnosed with wound infection and eventually required a revision of her left below the knee amputation.

When the resident returned to the facility, the facility resumed appropriate assessment of the resident's wound and coordinated care with a home care to provide management of the resident's wound.

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: no, the resident was hospitalized.
Family/Responsible Party interviewed: no, the resident did not have any family.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action required.

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
	34299	A. BUILDING: _____ B. WING _____	C 01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS AT WATERTOWN	409 JEFFERSON AVENUE SW WATERTOWN, MN 55388

(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 January 6, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL342996945M/HL342991491C. No correction orders are issued.	0 000		