Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL343895923M
Compliance #: HL343898584C

Date Concluded: November 26, 2024

Name, Address, and County of Licensee Investigated:
Riverview Landing
9200 Quantrelle Ave NE
Otsego, MN 55330
Wright County

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

Evaluator's Name: Lisa Coil, RN, BSN
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 it did not provide services overnight. The resident was found on the floor in the morning and transferred to the emergency department for evaluation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While it was true services were missed on the night shift, the time of the resident's fall could not be determined nor a connection between the missed service and the fall. When the resident was found by the facility, appropriate cares were provided.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record, facility internal investigation, personnel files, and staff schedules.

The resident resided in an assisted living facility. The resident's diagnoses included heart failure and weakness. The resident's service plan included assistance with toileting, bed mobility, and dressing. The resident's assessment indicated the resident was independent with walking, was orientated, and was able to use her call light.

An incident report indicated the resident was found on the floor in her room one morning. The report indicated the resident was lying over her walker and had a laceration to her left upper arm. The report indicated 911 was called and the resident was transported to the emergency room for treatment.

The progress indicated the resident was found on the floor next to her bed at 9:50 a.m. with blood on the carpet near the resident's face and arm. The note indicated the resident had a laceration on her left outer arm, but staff were unable to tell where else the resident was bleeding from and called for emergency services who instructed the staff member(s) to not move the resident.

The next day the progress notes indicated a nurse talked to the resident's family member. The family member told the nurse the resident received five stitches on the inside of her left arm and eight stitches on the outside of her left arm. The family member also told the nurse the resident had a bladder infection.

On the third day after the fall the progress notes indicated the resident returned to the facility. The notes indicated the resident was alert and oriented, had bruises on both thighs, across her chest, and on the left side of her forehead. The note indicated the resident had a dressing covering the wound on her upper left arm.

The Service Checkoff List indicated the resident had a scheduled service for toileting with physical assist scheduled for 1:00 a.m. every morning. The list indicated the resident had multiple services scheduled for 8:30 a.m. every morning, including bed making, physical assist with bed mobility, dressing, and toileting.

On the night shift prior to the fall, the 1:00 a.m. toileting service was signed off as completed by unlicensed caregiver #1.

During an interview, unlicensed caregiver #1 stated he was assigned to the resident the night shift prior to the fall. Caregiver #1 stated the night was busy, another resident was calling for help and he was in that resident's room a lot. Caregiver #1 stated he did not complete the resident's scheduled 1:00 a.m. service but he mistakenly signed off that he had completed the service.

A review of the documentation for the 8:30 a.m. services indicated the services for toileting, dressing, compressing stockings and weight were signed off as completed by unlicensed caregiver #2. The 8:30 a.m. services for bed mobility, grooming and hearing aid placement were

circled, which indicated they were not completed. In addition, the 11:00 a.m. services for toileting and escort to meals were signed off as completed. However, further review of documentation indicated there was a “service note,” Bed mobility, Grooming, and Hearing aids were “accidentally” pressed which showed an error in documentation had been identified.

During an interview, unlicensed caregiver #2 stated she was the one who found the resident lying on the floor in the morning. Caregiver #2 stated she went to the resident’s room to provide morning cares around 9:20 a.m. to 9:25 a.m. when she saw her lying on the floor. Caregiver #2 stated the resident was bleeding and holding a hanger like she was attempting to get dressed. Caregiver #2 stated she did not get the resident’s 8:30 services done on time because she was busy with other residents. Caregiver #2 stated the only service she provided to the resident that morning was bed making. Caregiver #2 stated she may have signed off other services by mistake but would have “cancelled” them. [This was consistent with the documentation reviewed during the investigation].

During an interview, the resident stated she was getting up from bed and fell in her bathroom doorway when her walker got away from her. The resident stated she had a call light on her wrist or around her neck but could not reach it after she fell. The resident stated she did not have to call staff for help to walk at that time.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated the incident and sent the resident to the hospital.

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
	34389	A. BUILDING: _____ B. WING _____	C 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW LANDING	9200 QUANTRELLE AVENUE NE OTSEGO, MN 55330

(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 10, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL343898584C / #HL343895923M. No correction orders are issued.	0 000		