Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305371820M
Compliance #: HL305379622C

Date Concluded: July 16, 2024

Name, Address, and County of Licensee Investigated:
Riverside Assisted Living
812 East Centre Street
Royalton, MN 56373
Morrison County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Inconclusive

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 (AP) abused the resident when the AP roughly transferred the resident to bed, causing a bruise on her leg.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The resident reported the AP was rough with cares causing a bruise to her leg and tightened the gait causing pain. The AP denied performing rough care services to the resident. The AP stated he used a gait belt when he assisted the resident with a stand, pivot transfer in a smooth, unrushed manner. The AP stated there was an instance the resident notified him the gait belt was too tight, at which time he loosened it for the resident's comfort. Staff reported the resident was a reliable reporter however, the resident had documented hallucinations on the day of the alleged incident.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed staff interaction and cares performed with the resident.

The resident resided in an assisted living facility. The resident's diagnoses included stroke and chronic pain. The resident's service plan included assistance with bed mobility and transfers. The resident's assessment indicated the resident had constant pain, mild confusion, and verbal aggression. The resident used a wheelchair for mobility. The residents medical record notes indicated the resident frequently exhibited behavior episodes and pain.

The resident's service record indicated the resident experienced hallucinations the same day she reported the allegation of abuse to facility staff.

The AP worked as an unlicensed personnel (ULP) at the facility through a staffing agency company. The resident reported to facility staff the AP was very rough with her cares and threw her in bed, causing a bruise to her leg. The resident stated the AP applied the gait belt tightly across her breasts, causing pain.

During an interview, ULP-1 stated the resident was a reliable reporter. ULP-1 stated the resident had complained that her neck hurt a few days after the AP massaged her neck. The resident told ULP-1 the AP threw her in bed. ULP-1 denied seeing any bruises on the resident. ULP-1 stated the resident never complained about any other staff members handling her roughly.

During in interview, ULP-2 stated the resident was a reliable reporter. ULP-2 stated when the facility began using agency staff, the resident had a hard time with staff of races other than her own help her. The resident began stating she did not want certain staff to help her. ULP-2 stated there were other residents who did not want the AP to help them due to his poor attitude, and other staff complained about his poor attitude as well. ULP-2 stated she noticed a small bruise on the resident but did not recall what explanation the resident gave on how she obtained the bruise.

During an interview, the facility director stated they had not had any previous complaints or concerns about the AP's quality of work or how he treated the residents. The director stated during her investigation, the resident did have a bruise on her leg and the resident stated the AP caused them.

During an interview, a family member stated the resident had never complained about any rough handling prior to this claim. The family member stated the resident had some small bruises at one point and the resident stated the AP caused the bruises. The family member stated she did not take the resident to see a doctor related to the abuse claims. The family member stated she felt the residents was safe at the facility and liked living at the facility.

During an interview, the resident stated the AP grabbed her arm, threw her in bed and told her that is how it is going to be. The resident stated the AP placed the gait too tight on her breasts, and when she told him it hurt, he told her that is how it is going to be. The resident stated the AP was mean and rude. The resident stated the AP hurt her neck from throwing her in bed, and she went to see a chiropractor.

During an interview, the AP denied performing rough cares with the resident. The AP stated the resident preferred the gait belt placed below her breasts, and if it was ever too tight, he loosened it to her comfort preference immediately. The AP stated the resident was not a reliable reporter due to occasional confusion.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(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;

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

Action taken by facility:
The facility investigated the allegation. The AP is no longer working shifts at the facility.

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
	30537	A. BUILDING: _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE ASSISTED LIVING	812 CENTRE STREET EAST ROYALTON, MN 56373

(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: #HL305373456C /#HL305373342M #HL305379622C /#HL305371820M On May 30, 2024, 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 12 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL305373456C/#HL305373342M, tag identification 2360. No correction orders are issued for #HL305379622C /#HL305371820M .	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 Facilities. 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 evaluators ' 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 FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	