DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL318849268M
Compliance #: HL318846985C

Date Concluded: April 5, 2024

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: 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 residents when resident #1 pushed resident #2 to the ground, resulting in broken ribs.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although resident #1 was involved in a physical altercation with resident #2, it was an isolated incident. Resident #2 sustained fractured ribs, received treatment at the hospital, and subsequently returned to their baseline health condition.

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

The resident #1 resided in an assisted living facility. The resident's diagnoses included schizophrenia. The resident's service plan included supervision in all activities of daily living.

The resident #2 resided in an assisted living facility. The resident's diagnoses included major depressive order and anxiety. The resident's service plan included supervision in all activities of daily living.

One day, resident #1 went out to smoke, and resident #2 began threatening him. Resident #2 then started wheeling himself toward resident #1, stating he would harm him. As resident #2 attempted to strike resident #1, resident #1 pushed him in his wheelchair. Resident #1 returned to his chair, resident #2 got up and approached him once more. Resident #2 attempted to attack resident #1 again, prompting resident #1 to push him to the ground and restrain him by placing his knee on top of resident #2.

The facility's internal investigation indicated the staff members intervened and called law enforcement. The facility sent resident #2 to the hospital where he was diagnosed with a broken sternum and ribs. The same document indicated the facility updated the residents' care plans to include more frequent interventions with follow-up conversations with the residents.

During an interview, a manager stated the incident occurred at midnight. The manager said resident #1 was outside smoking alone when resident #2 approached him and began to provoke and threatening physical violence, to which resident #1 suggest they "settle the matter". Staff members were not present at the onset of this altercation but noticed commotion outside and went outside to see what was going on. Resident #2 was sent to the hospital that night, the implementation of safety checks for both residents were initiated. She stated staff members encouraged both residents to use their call lights whenever they felt triggered and ensured they were readily available. Additionally, staff conducted a room search the night before resident #2 returned home from the hospital and found a pocketknife. The manager stated one of the reasons underlying conflict among resident's was borrowing and lending between residents and so the facility coordinated with the case manager(s) to reduce the opportunity for such transactions between residents.

During an interview, an unlicensed caregiver stated she was assisting another resident when the incident occurred. She went outside and found both residents engaging in conflict, so she instructed resident #1 to return to his room, which he did. The caregiver said resident #2 wanted to go to the hospital, so she called 911. Since this incident, staff members made sure to keep the residents separated and encouraged them to use the call light for assistance when needed. The caregiver stated there have been no further incidents involving the two residents since.

During an interview, resident #1 stated he went to smoke, and resident #2 followed him outside, threatening physical violence. Resident #2 attempted to punch him, prompting resident #1 to push him to the ground and placed his knee on resident #2's chest.

During an interview, resident #2 said resident #1 pushed him down onto his chair and confronted him. He further stated resident #1 pushed him onto his back on the pavement and applied significant force with his knee onto his chest, resulting in some of his bones being broken. Resident #2 called for help, and the staff called an ambulance, which transported him to the hospital for treatment.

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: No.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
At the time of the incident 911 was called. Both residents were placed on more frequent checks. The facility arranged changes in the way funds were made available to reduce the opportunity for borrowing and lending among the residents.

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 03/25/2024

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 March 25, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL318849268M/HL318846985C . No correction orders are issued.	0 000		