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 #: HL326492960M
Compliance #: HL326492761C

Date Concluded: September 12, 2024

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, 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 they failed to seek medical evaluation in a timely manner. Additionally, the facility neglected the resident when they left her unattended at the front desk of the hospital with no communication to the hospital staff.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility noted a change of condition in the resident and transported the resident to the hospital for a medical evaluation. The facility staff assisted the resident to check in at the emergency room, and per the directive of the front desk staff, left the resident in the care of the hospital staff.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator attempted to contact hospital staff without success. The investigation included review of the resident records, death record,

hospital records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included vascular dementia and chronic obstructive pulmonary disease (COPD). The resident's service plan included assistance with all activities of daily living. The resident's assessment indicated the resident was nonverbal and wheelchair bound.

The resident's spouse and facility staff stated the resident resided at the facility for multiple years, and the spouse visited her multiple times every week. Staff noted the resident appeared had a decreased appetite a few days after the spouse went out of town on vacation. The resident had a known pattern to appear depressed when her spouse was not able to make it to the facility to see her. The staff updated the spouse on the change and monitored the resident. Staff noted a further decreased appetite and a change in the resident's vital signs. The facility transported the resident to the hospital for evaluation. The nurse assisted the resident with checking in at the emergency and the hospital desk staff stated the hospital medical staff were coming right out to get her and the resident could wait right there with her. Staff updated the resident's spouse, and he met the resident at the hospital. The resident's diagnosis was hypernatremia (high sodium blood levels) and leukocytosis (an increase in white blood cells.) The resident returned to the facility the following day on hospice services. The resident passed away three days later.

The resident's nurse's notes indicated staff updated the resident's spouse on her initial change in condition. The spouse stated he would come see the resident the following day when he returned from vacation. The notes indicated the resident continued to decline and the facility nurse transported her to the emergency room for evaluation.

The resident's hospital record indicated the medical evaluation did not reveal any acute medical concern and recommended hospice services due to advancing dementia.

The resident's death record indicated the cause of death was vascular dementia and hardening of the arteries in the brain.

During an interview, the nurse stated the resident had a history of having a change in her abilities and mood when she missed her spouse. The nurse stated the facility updated the spouse when the staff noted a change in the resident's condition, and he was not concerned at that time. The nurse stated the spouse said the resident does this when she is lonesome for him and that he will come see her in a day or two. The nurse stated staff noted a further decline when there was a change in the resident's vital signs, so she brought the resident to the hospital. The nurse stated she told the hospital staff she does not speak, and that there was just "something off" with the resident. The nurse stated the hospital staff that checked the resident in said the resident could stay with her as the medical staff were on their way to get her. The

nurse stated the resident's spouse was on his way to the hospital. The nurse denied leaving the resident alone.

During an interview, the licensed assisted living director (LALD) stated staff notified her the resident had not eaten well that day. The LALD asked the resident if she was missing her spouse and the resident grinned. The LALD stated she spoke to the resident's spouse about the noted change in the resident and he was not concerned stating you could tell a difference in the resident if he missed coming to the facility for a few days. The LALD stated the resident continued to have a poor appetite and her pulse had changed so they brought her to the emergency department for evaluation. The LALD stated she notified the spouse and he stated he would meet her at the hospital.

During an interview, an unlicensed personnel (ULP) stated the change in the resident came on fast. The ULP stated staff monitored the resident nearly constantly up until she went to the hospital. The ULP felt the facility properly handled the resident's change of condition.

During an interview, a family member stated he visited the resident two to three times a week. The spouse stated he had gone out of state on vacation, and upon his return he went to see the resident. The spouse stated he noted the resident was not eating well, and he figured it was because she had missed him. The spouse stated he met the resident in the emergency room as the staff was getting blood from the resident. The spouse stated the doctor did not find anything wrong with the resident other than her sodium level being off. The spouse stated the doctor told him the resident had about four days to live. The spouse stated he felt the facility met the resident's needs and she received good care at the facility. The spouse stated he had no concerns.

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, deceased.

Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility monitored the resident's change in condition and transported the resident to the hospital for medical evaluation.

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 08/27/2024

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 On August 27, 2024, the Minnesota Department of Health initiated an investigation of complaint HL326492761C/HL326492960M and HL326493626C/HL326493425M. No correction orders are issued.	0 000		