Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326493425M
Compliance #: HL326493626C

Date Concluded: September 10, 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 provide standards of care to meet the resident's toileting and wound care needs. Staff left the resident in bed after having a bowel movement for an extended period. Additionally, the facility failed to properly care for the resident's wounds.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The investigation lacked evidence of neglect. The facility provided adequate care per provider's orders and the resident's preferences. The facility completed the residents wound care as ordered and the wounds were showing improvement. The resident had a patterned history of refusing care and removing his wound dressings.

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

facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed staff providing care to the resident.

The resident resided in an assisted living facility. The resident's diagnoses included idiopathic neuropathy (a condition when nerves outside of the brain and heart are damaged, causing pain, numbness, and tingling) and heart failure. The resident's service plan included assistance with toileting, dressing, bathing, and transfers. The resident's assessment indicated the resident was alert, oriented, and had a left below the knee amputation. The resident used a full body mechanical lift to transfer in and out of bed.

The resident admitted to the facility with a left below the knee amputation and wounds to the right leg. The resident preferred to stay in bed, and only got up in his wheelchair when he needed to for appointments outside the facility. The resident was continent of his bowel and bladder but preferred to stay in bed for toileting needs, utilizing other methods, rather than getting up to use the toilet. The resident did not always alert staff when he had a bowel movement so they could help him timely. The resident preferred to lay in bed naked, with only the bed sheet covering him for his own personal comfort. The facility staff completed wound care as ordered and encouraged the resident to attend his wound care clinic appointments despite his refusals to go.

While on site, the investigator did not note any odor in the resident's room. The resident appeared clean and well groomed. The resident's wound dressings were clean and intact.

The resident's treatment administration record indicated staff completed wound care every Monday, Wednesday, and Friday per the provider's orders. Staff completed a wound assessment weekly.

The resident's provider notes indicated the resident's wounds looked improved despite the resident being non-compliant with keeping dressings in place.

The resident's nurse's notes indicated the resident refused to go to the wound care clinic appointment.

During an interview, the nurse stated when the resident arrived at the facility, he had not been out of bed in three years. The facility obtained physical therapy services for the resident, but the resident refused the services. The nurse stated the resident knows when he needs to go to the bathroom, refuses assistance to the toilet, chooses other methods while in bed. The nurse stated the resident did not always tell staff when he goes to the bathroom; that it depended on his mood. The nurse stated the resident kicked the wound dressing on his foot off frequently but does not stated why he does it. The nurse stated they have attempted to use pillows under the foot and foam boots, but the resident kicks everything off. The nurse stated the resident sees his doctor every Wednesday who stays on top of his wound care well.

During an interview, the facility director stated the resident does not always allow staff to assist with his cares. The director stated the resident was refusing to attend wound care clinic appointments and frequently removes the dressing on his foot. The director stated the resident has not voiced any concerns about his care at the facility. The director stated the resident preferred to lay naked in bed. The director stated the facility was meeting the residents care needs.

During an interview, an unlicensed personnel (ULP) stated the resident refused to have a bowel movement in the bathroom and chose other methods while in bed. The ULP stated the resident will only have a bowel movement in bed on the disposable pad. The ULP stated she did not help the resident dress because he refuses to wear clothes unless he is going out of the facility. The ULP stated the resident has never stated any concerns about his care to her.

During an interview the resident stated he did not have any concerns about his care at the facility. The resident stated the staff would like him to have a check and change program or go to the bathroom, but he declined. The resident denied staff leaving him unassisted in bed after defecating for an extended period. The resident stated he did not feel there was a purpose of going to a wound clinic, and the facility nurse did his wound care appropriately. The resident denied the staff leaving his wound undressed. The resident stated he did not like to wear clothes in bed. The resident stated he was glad to be at the facility and not at his previous one.

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: Not applicable, resident was own responsible person.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility completed the residents wound care per orders, and provided incontinence care timely.

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		