Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326494583M
Compliance #: HL326497824C

Date Concluded: May 15, 2023

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:
Lisa Coil, RN Special Investigator

Finding: Substantiated, facility responsibility

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 staff failed to provide supervision and the resident exited the facility unsupervised. The resident walked to a gas station, fell outside, and cut his head. The gas station employee called for an ambulance, which transported the resident to the emergency room (ER) for treatment and hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Although the resident was sent to the ER for treatment, the facility failed to identify or implement interventions to prevent the resident from exiting the facility unsupervised or falls.

The investigator conducted interviews with nursing staff and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident's

record, and facility policies and procedures. Also, the investigator toured the facility and completed observations.

The resident resided at an assisted living facility. The resident's diagnoses included Parkinson's disease. The resident's service plan included supervision to walk, use of a front wheeled walker, and identified him as at risk for falls. The resident's assessment indicated decreased muscular coordination, balance problems while walking, forgetfulness, and disorientation to place and time. The assessment further indicated the resident wandered inside the facility communal areas but did not leave the building.

The resident's medical record indicated he fell down multiple times in the facility during the ten weeks prior to his hospitalization beginning in the late fall and ending in winter. The same documents indicated he began trying to exit the facility without supervision in the last week prior to his hospitalization.

During the first week the resident's incident report indicated the resident was found on the bathroom floor with an abrasion on his back. The report indicated the resident did not use the call system appropriately; however, actions taken to prevent future falls indicated to always have the call pendant within reach.

During the third week the resident's incident report indicated the resident lost his balance and fell while walking. The report indicated the resident did not use his pendant because he was not wearing it. The report indicated actions taken to prevent future falls were to assess the need for transfer and ambulation assistance.

Early one morning during the fourth week the resident's incident report indicated the resident was found on the bedroom floor, had a cut to his left ear, a suspected head injury, and was transported to the ER. The report indicated the resident did not use the call system appropriately. The report indicated actions taken to prevent future falls were to provide the resident with a front-wheeled walker for walking. The resident's medical record indicated he return later the same morning.

However, a second incident report for the same day indicated the resident fell a second time shortly after returning from the hospital. The second incident report indicated the resident was found on the bathroom floor with a cut to his head and laying in a "puddle" of blood. The report indicated the resident did not use the call system appropriately and was walking from the bed to the bathroom by himself. The resident was transported to back to the ER for evaluation and treatment. Further review of the report indicated the area labeled "actions taken to prevent future falls" was left blank. The resident returned to the facility the following day.

The resident's hospital record from this hospitalization indicated the resident admitted to the ER with bleeding in the space surrounding the brain, a laceration of the left ear, and a cut on the

head. The record indicated the resident had been in the ER earlier because of another fall and both falls caused multiple injuries. The record further indicated, as discharge instructions, the resident required a fall risk assessment and implementation of falls precautions as needed when back to the facility.

During the fifth week the resident's incident report indicated the resident fell out of bed. The same report indicated the resident did not use the call system appropriately. Further review of the report indicated the area labeled "actions taken to prevent future falls" was blank.

Later during the fifth week the resident's incident report indicated the resident rolled out of bed, was found on the floor, and got bump on the left side of his forehead with a small cut. The report indicated the resident did not use the call system appropriately. The report indicated actions taken to prevent future falls were to assist with toileting.

Approximately twelve hours later the resident's incident report indicated the resident rolled out of bed again. The report indicated the resident did not use the call system appropriately. Further review of the report indicated the area labeled "actions taken to prevent future falls" was blank.

During the sixth week the resident's incident report indicated the resident fell from a wheelchair while attempting to stand up. The report indicated the resident did not use the call system appropriately. Further review of the report indicated the area labeled "actions taken to prevent future falls" was blank.

During the ninth week the resident's incident report indicated the resident was found on the floor in his bedroom doorway on top of his walker, the resident sustained a skin tear laceration and a bruise. The report indicated the resident did not use the call system appropriately. The resident's progress notes indicated the walker may have caught the edge of the couch, so the room was rearranged to clear a wider walkway.

During the tenth week the resident's incident report indicated the resident required a staff member to direct him back into the building on two separate incidents. The report indicated the resident was not dressed appropriately for the weather when he was outside for the incidents. The report indicated during the first incident the resident was in a fenced area trying to open the gate and said he was trying to get out to go home. The resident's progress note indicated during the second incident he was redirected back into the facility from the main foyer area. Neither the incident report nor the progress notes described interventions put in place to address the resident's exit-seeking behavior.

The next day the resident's incident report indicated the resident fell while ambulating in his room and hit his head. The report indicated his walker was within reach and the resident did not use the call system appropriately. The area labeled "actions taken to prevent future falls" was blank.

Two days later the resident's incident report indicated the resident was found on the bathroom floor and sustained a skin tear. The report indicated the resident did not use the call system appropriately. A review of the document indicated the area labeled "actions taken to prevent future falls" was blank.

Less than 24 hours later the resident's incident report indicated a worker at the gas station next to the facility called 911 because the resident fell at the gas station. The report indicated the ambulance and police officer arrived on scene and the resident was transported to the ER. The resident's progress notes indicated law enforcement came to the facility and informed facility staff members the resident fell at the gas station, sustained a cut on his head and was transported to the ER. The note further indicated the resident admitted to the hospital and had not returned to the facility.

The resident's medical records indicated he did not return to the facility.

During an interview, a family member stated the resident had a history of falls related to his Parkinson's and three out of the last four falls resulted in a brain bleed. The family member stated the resident did use a walker and staff had rearranged his room so he would not run into things with it. The family member stated he thought there was always staff on first floor to keep an eye on the resident. The family member stated the resident passed away during the month following the last incident at the facility.

During an interview, an unlicensed staff member stated the resident was one of two residents who resided on the first floor. The staff member stated she and a coworker were on other floors assisting residents with bedtime cares when a walkie talkie notification came in for assistance at the main entrance. The staff member stated a law enforcement officer came to the facility and notified them the resident had fallen at the gas station next door and was transported to the hospital. The staff member stated she had taken the resident to his room approximately a half an hour prior to being notified of the incident. The staff member stated the resident had a walker but did not use it often, had a history of wandering, had left the facility before, and a history of falls.

During an interview, the nurse stated the resident moved in with a history of multiple falls related to Parkinson's. The nurse stated the resident's falls increased about four months prior to discharge as he began to stumble more while ambulating. The nurse stated there were incidents she knew about, but she did not consistently complete the follow-up or put interventions in place.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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:
Resident was admitted to the hospital and did not return to the facility. The facility completed an internal investigation.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Aitkin County Attorney
Aitkin City Attorney
Aitkin Police Department

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 04/05/2023

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 ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL326497824C/#HL326494583M On April 5, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 38 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL326497824C/#HL326494583M, tag identification 2360.	0 000	The Minnesota Department of Health documents 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the Surveyors and/or Investigators ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the state correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys and/or complaint investigations. 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.	

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0 000	Continued From page 1	0 000	THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPY AND LEVEL ISSUED PURSUANT TO THE MINN. STAT. § 144G.31, SUBDIVISION 2 and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, 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 reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. Additional correction orders associated with R1 were issued with the project number #SL32649015-2 during an onsite visit dated January 23 and 24, 2023. The specific correction orders included 450 and 1620 (enclosed is a quick report detailing tags 450 and 1620).	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report for details of this tag.	