Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326496126M
Compliance #: HL326491542C

Date Concluded: May 25, 2023

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
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 a resident when a resident was found on the ground outside the building on two occasions while experiencing confusion.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident fell in the parking lot, resulting in a thoracic injury. Approximately a month later, the resident left the facility without supervision and fell by train tracks located nearby to the facility. The facility did not document interventions to prevent recurrence between these two incidents.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of resident's records, facility's policies and procedures,

incident reports, and the resident's external medical record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident was living in an assisted living facility. Her diagnoses included dementia and diabetes. The resident's service plan indicated independence in activities of daily living such as hygiene, dressing, and toileting but required assistance with meals, housekeeping, medication administration and diabetes management. The resident's assessment indicated she was at risk for falls necessitating the use of a four-wheeled walker while walking.

The resident's fall report indicated she left the facility and walked to the store to buy cookies. However, on her way back to the facility she lost her balance and fell in the parking lot. The same document indicated the resident had lower back pain after the fall and went to the emergency room. The resident did not require hospitalization and returned to the facility.

The resident's assessment completed earlier the same day as this fall indicated the resident had a history of "wandering" on one occasion within the facility but no exit-seeking. The same document indicated the resident at times told staff members her parents were coming to have a meal with her but did not go searching for them.

During the course of this investigation, the resident's medical record indicated she left the facility unsupervised on two other occasions as described below.

About a month after the first event, the resident's incident report indicated the resident walked out the front door and was found near railroad tracks by the facility's property. A review of the documents provided by the facility did not identify new interventions put in place after this second incident.

A review of the resident's medical record did not identify interventions the facility put in place to address the resident's exit-seeking behavior between the first and second event a month later.

Three days later the resident's progress notes indicated the resident was found once again outside the facility heading towards a nearby gas station. After this third unsupervised exit the resident's medical record indicated the facility began seeking alternative placement along with regular check-ins with the resident.

A review of the resident's medical record did not identify interventions the facility put in place to address the resident's exit-seeking behaviors between the second and third incident.

During an interview, the resident's family member stated the facility informed her the resident had left the facility unsupervised and fell. The family member stated the incident should not have occurred and emphasized the resident required constant supervision. According to the

family member, the resident should not be allowed to leave the building unattended since she would not be able to safely return on her own.

During an interview, an unlicensed staff member #1 stated the resident was capable of walking independently but the resident was confused most of the time as reflected by the resident talking about her parents like they were present, but this was not true. The resident should not be allowed to go outside without supervision. Staff member #1 stated the resident at times wrote her name in the sign-out book, but she did this in imitation of other people doing the same. However, the resident would sign-out when she had no place to go and stayed in the building. Staff member #1 stated the resident could be prevented from the leaving the building if someone was working at the front desk which was covered from 8:00 a.m. to 5:00 p.m. After 5:00 p.m. no one worked at the front desk, which made it more challenging to ensure the resident did not leave the facility without supervision.

During an interview, an unlicensed staff member #2 stated she was not aware of the first incident, but she was one of two staff members working on the day of the second incident. Staff member #2 stated the resident was confused, repeatedly attempted to exit the facility, and it was difficult for the staff members to monitor the resident while providing care to other residents. Regarding the second incident, staff member #2 stated a gentleman and his son happened to drive by and witnessed the resident falling on the train track so they stopped to help her. Meanwhile, staff member #2 was searching for the resident because the resident had activated her “buzzer” (a call pendant). Eventually, the staff members realized the resident was outside and helped her return to the building. Although it was uncertain whether the resident had hit her head, she began vomiting, prompting the staff members to contact the on-call nurse and arrange for the resident to be transported to the hospital.

During an interview, the director talked about the first incident and stated the resident had signed out and went to a gas station to purchase cookies. Unfortunately, during this outing, the resident fell and hit her head, necessitating her hospitalization. The director mentioned that earlier that day, a nurse had assessed the resident and did not express any concerns about her tendency to leave the facility without supervision. Regarding the second incident, the resident told the director she left the building because her “mother” had called her, so she walked across the railroad track towards her childhood home. Staff members eventually found her sitting on the ground, and they escorted her back to the facility. Due to the resident's subsequent vomiting, it was uncertain whether she had sustained another head injury, so she was once again sent to the emergency room. The director also stated that the resident had attempted a similar action the day before the interview, trying to go to the gas station because she believed she heard a voice instructing her to do so. The director acknowledged the need for interventions to address the resident’s exit-seeking and stated the facility had contacted a psychiatrist to evaluate the resident's condition.

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, due to confusion.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility sent the resident to the hospital twice and notified the family.

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.

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 name 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 05/20/2023

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: #HL326491542C/#HL326496126M #HL326492282C/#HL326496544M #HL326491569C/#HL326496144M On May 8, 2023, 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 36 residents receiving services under the provider's Assisted Living License. The following correction order are issued for #HL326491542C/ #HL326496126M, and #HL326492282C/#HL326496544M: tag identification 2310 and 2360. No correction orders were issued for #HL326491569C/#HL326496144M.	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.	
02310 SS=H	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have provide services based on the resident's needs according to an up-to-date service plan after two resident reviewed (R1, R2) successfully exited the facility without supervision on multiple occasions. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1	02310		

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02310	Continued From page 2 R1 admitted to licensee on January 27, 2020, with diagnoses including dementia disease and diabetes. R1's assessment dated April 7, 2023, at 4:24 p.m., indicated R1 had a history of "wandering" on one occasion within the facility but no exit-seeking. The same document indicated R1 at times told staff members her parents were coming to have a meal with her but did not go searching for them. It also indicated R1 was at risk for falls necessitating the use of a four-wheeled walker while walking. R1's progress notes dated April 7, 2023, at 10:00 p.m. indicated R1 left the facility and walked to the store to buy cookies at approximately 6:30 p.m. earlier the same day. However, on her way back to the facility she lost her balance and fell in the parking lot. The same note indicated R1 was sent to the hospital for evaluation. The CT scan showed R1 sustained a distraction injury and incomplete carrot stick fracture of the superior T8 endplate. R1's incident report dated May 13, 2023, indicated R1 walked out of the front door and was found by the rail's road track behind fence by the gas station. R1's record lacked evidence nursing added did not identify an assessment or interventions updating the resident's service plan based on resident's needs service plan after the incidents of successful exit-seeking with subsequent falls on April 7, and May 13, 2023. During an interview on May 10, 2023, at 10:31 a.m., a family member (FM)-A stated the facility informed her R1 had left the facility unsupervised	02310		

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02310	Continued From page 3 and fell. FM-A stated the incident should not have occurred and emphasized the resident required constant supervision. According to FM-A, R1 should not be allowed to leave the building unattended since she would not be able to safely return on her own. During an interview on May 15, 2023, at 1:43 p.m., the unlicensed personnel (ULP)-B stated R1 was capable of walking independently but R1 was confused most of the time. ULP-B confirmed R1 should not be allowed to go outside without supervision. ULP-B stated the resident at times signed her name in the sign-out book, but she did this in imitation of other people doing the same. However, R1 would sign-out when she had no place to go and stayed in the building. ULP-B stated R1 could be prevented from the leaving the building if someone was working at the front desk which was covered from 8:00 a.m. to 5:00 p.m. After 5:00 p.m. no one worked at the front desk, which made it more challenging to ensure the resident did not leave the facility without supervision. During an interview on May 15, 2023, at 3:46 p.m., ULP-C stated she was not aware of the first incident, but she was one of two staff members working on the day of the second incident. ULP-C stated R1 was confused, repeatedly attempted to exit the facility, and it was difficult for the staff members to monitor R1 while providing care to other residents. Regarding the second incident, ULP-C stated a gentleman and his son happened to drive by and witnessed the resident falling on the train track, so they stopped to help her. Meanwhile, ULP-C was searching for the resident because the resident had activated her call pendant. Eventually, ULP-C realized R1 was outside and helped her return to the building.	02310		

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02310	Continued From page 4 Although it was uncertain whether the resident had hit her head, she began vomiting, prompting the staff members to contact the on-call nurse and arrange for R1 to be transported to the hospital. During an interview on May 17, 2023, at 4:17 p.m., the registered nurses (RN)-D talked about the first incident and stated R1 had signed out and went to a gas station to purchase cookies. Unfortunately, during this outing, R1 fell and hit her head, necessitating her hospitalization. RN-D stated earlier the same day a nurse had assessed R1 and did not express any concerns about her tendency to leave the facility without supervision. Regarding the second incident, R1 told the RN-D she left the building because her "mother" had called her, so she walked across the railroad track towards her childhood home. Staff members eventually found her sitting on the ground, and they escorted her back to the facility. Due to the resident's subsequent vomiting, it was uncertain whether she had sustained another head injury, so she was once again sent to the emergency room. RN-D stated R1 exited the facility again the day before the interview [May 16, 2023] trying to go to the gas station because she believed she heard a voice instructing her to do so. RN-D acknowledged the need for interventions to address the resident's exit-seeking and stated the facility had contacted a psychiatrist to evaluate the resident's condition. R2 R2's diagnoses included dementia, glaucoma, and macular degeneration. R2's care plan dated March 24, 2023, indicated R2 was independent with ambulation with use of a walker. R2's Individual Abuse Prevention Plan (IAPP), dated	02310		

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02310	Continued From page 5 March 24, 2023, indicated R2 had vision impairments, made poor decisions, was at risk for elopement, and had frequent safety checks. The document further indicated R2 felt he should be able to leave the facility on his own, made statements of not wanting to be at the facility, but had never attempted to leave the facility or property. R2's progress note, dated March 15, 2023, at 2:17 p.m. indicated R2 had been more confused for the past four days. The note indicated R2 had been wandering into other resident's rooms during the night waking them from sleep and accusing them of taking his belongings. R2's progress note, dated March 16, 2023, at 4:00 p.m., indicated R2 had been going outside into the parking lot wandering, trying to get to the store. The note indicated it was clear R2 did not know how to get to the store. R2's progress note, dated March 16, 2023, at 5:37 p.m., indicated R2 had wandered into other residents' rooms, was unhappy he could not have his cigarettes, and wanted to go to the store on two separate occasions, once for cigarettes and once for juice. Staff members redirected him. R2's progress notes, dated between March 24, and April 5, 2023, included five entries indicating family and licensee administration were working on relocating R2 to a secured facility. R2's treatment assistance record (TAR), dated April 2023, indicated R2 was on hourly safety checks. A review of correction orders issued subsequent to the survey conducted on April 18, 2023, R2	02310		

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02310	Continued From page 6 exited without supervision on the same day. The same document indicated an unlicensed caregiver said R2 had a history of leaving the facility without supervision and required redirection from the nearby gas station. A review of R2's medical record did not find documentation of the events described the unlicensed caregiver. [R2 was identified as R4 in the previously issued correction orders]. R2's progress note, dated April 26, 2023, at 5:00 a.m., indicated R2 had talked about leaving the facility because he thought someone picked him to go somewhere. R2's progress note, dated May 5, 2023, at 4:18 p.m., indicated a staff member was on her way back from doing a store run and came across the resident almost to the highway by the gas station. She escorted him back to the facility. The same documentation also indicated on the same date around 9:00 p.m., the resident walked out of the front door at least five times during a shift, and each time he was assisted back into the building by unlicensed personnel. A review of the R2's medical record provided by the facility did not identify assessment or interventions updating the resident's service plan based on resident's needs after the incident on May 5, 2023, to address the resident's exit-seeking behavior. The same document indicated the facility sought alternative placement but did not indicate an assessment of the resident or a review of the interventions in place at the time of the successful exit-seeking on May 5, 2023. During an interview on May 17, 2023, at 4:26 p.m., RN-D stated R2 had gone to a gas station	02310		

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02310	Continued From page 7 to buy cigarettes without staff present. RN-D mentioned R2 had visited the gas station numerous times in the past and was familiar with the route, so he could find his way back to the facility even though he was being legally blind. She also said a staff member found R2 on her way back to the facility after running errands. Following the incident, RN-D had a conversation with R2, emphasizing he was not allowed to leave the facility without staff. RN-D acknowledged the necessity for interventions to address the resident's tendency to seek exits and expressed the facility's efforts in contacting other facilities to find a more suitable placement for the resident. During an interview on May 24, 2023, at 4:20 p.m., ULP-F stated R2's cognitive functioning was inconsistent. It all depended on his mood. ULP-F also emphasized R2 was not allowed to go out of the facility by himself. During an interview on May 24, 2023, at 5:21 p.m., FM-E stated the facility had informed her R2 had managed to leave the facility and had gone down the street, ultimately tripping over the track. It happened last year, and she did not know anything about any recent incidents. FM-E further expressed concerns about R2's cognitive impairment and his blindness, which increased the risk of wandering and potentially leaving the facility unattended. She mentioned being afraid if the front door was unlocked, R2 might attempt to leave the facility. Additionally, the family member raised the issue of insufficient staff to adequately monitor and supervise R2 at all times. During an interview on May 26, 2023, at 1:15 p.m., ULP-G stated R2 had a tendency to wander around the facility. R2 was not permitted to go to the parking lot or the front door unaccompanied.	02310		

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02310	Continued From page 8 However, the facility's front door was not locked, so if R2 managed to leave, staff members would need to guide him back inside. ULP-G confirmed R2 attempted to reach the parking lot multiple times a day or week, depending on his mood. ULP-G expressed concerns about R2 leaving the facility unnoticed. Despite her efforts to prevent the resident from leaving, she acknowledged the challenges in doing so, particularly when attending to the care needs of other residents. ULP-G highlighted the inability to provide constant supervision due to insufficient staffing levels. The licensee's 2.25 Incident Report policy dated January 1, 2023, indicated any incident involving a resident must be reported to management and an incident report form should be completed to document what happened. The policy indicated all incident reports related to residents will be kept in their records. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
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 two of two resident(s) reviewed (R1, R2) were free from maltreatment. Findings include:	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

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02360	Continued From page 9 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.	02360		