Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326497806M
Compliance #: HL326494616C

Date Concluded: October 21, 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, individual 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 properly secure the residents wheelchair in the facility van during transportation. When the van engaged the brakes, the resident fell out of the wheelchair and sustained a head injury.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. While the facility was not responsible for the neglect, an individual alleged perpetrator was responsible for the maltreatment. Although the facility had provided him training on this topic, the alleged perpetrator failed to secure the van's security buckles to the resident's wheelchair before leaving the parking lot.

The investigator conducted interviews with unlicensed staff. The investigation included review of the resident's record, staff personnel file, 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 congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). The resident's service plan included behavior management and medication administration. The service plan indicated the resident could walk but used a wheelchair when outside room, which he could manually propel or use to walk behind. The resident's assessment indicated the resident was independent, oriented, and his family did his shopping. The facility owned a van and offered rides to residents including those who used wheelchairs.

The resident's medical record included the alleged perpetrator, a van driver employed by the facility, provided a ride for the resident. The alleged perpetrator was making a turn and when he stepped on the gas and the resident fell back against the wheelchair ramp of the van and scraped his head. The report indicated the resident was assessed, the wound was cleaned, the medical provider was notified; however, emergency services was not called because the resident did not want to go to the hospital. The same document indicated the alleged perpetrator assured the back straps to the wheelchair was secured but thought the resident secured the front straps himself.

The alleged perpetrator's personnel file indicated training on use of the handicap accessible van included attaching the tie down mechanism to the floor anchors and the strap to the chair in all four (4) locations (two to the front, and two to the rear), and engage the brakes on the chair. The document further indicated the alleged perpetrator verbalized understanding and completed return demonstration on how to complete this safety task.

Additionally, the alleged perpetrator's personnel file indicated a member of management discussed the incident with the alleged perpetrator the day after it happened. The alleged perpetrator told the member of management he thought he heard the click of the anchors lock and the resident had attached the front straps to the wheelchair. The alleged perpetrator also told the member of management he would double check all strap and anchors to assure they are secured in the future and not allow residents to attempt to strap themselves in.

During an interview, the alleged perpetrator stated he received hands on training on how to secure a wheelchair in the van's security buckles from the licensee's director of nursing upon hire. The alleged perpetrator stated he secured the rear security buckles and allowed the resident to secure the front buckles. The alleged perpetrator stated he did not check the front buckles as he should have to make sure they were secure. During the trip to a store, the alleged perpetrator stated when he accelerated quickly during a turn, he heard a click sound as though the security buckle extended. When he looked in the rear-view mirror, he noticed the resident had fallen backward. Upon inspection of the buckles, the rear straps were still holding but the front were not. The alleged perpetrator stated the resident had a bump on his head with a little bleeding, which he cleaned up. The alleged perpetrator secured the front security buckles and completed the trip. Upon returning to the facility, the alleged perpetrator reported the incident

to the nurse and director of nursing. The alleged perpetrator was not provided retraining following the incident.

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: Yes.
Family/Responsible Party interviewed: No, the attempts to interview family were unsuccessful
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The nurse was notified the nurse upon return to the facility and she assessed the resident.

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 08/23/2023

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: #HL326497424M / #HL326494012C #HL326497425M / #HL326494013C #HL326497785M / #HL326494593C #HL326497806M / #HL326494616C #HL326497807M / #HL326494617C On August 22 and August 23, 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 33 residents receiving services under the provider's Assisted Living license. The following correction order is issued for: #HL326497425M / #HL326494013C, tag identification 2360 #HL326497785M / #HL326494593C, tag	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 identification 2360 #HL326497806M / #HL326494616C, tag identification 1620 and 2360.	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.	
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on document review, and interview the licensee failed to reassess and monitor change in needs when the resident exhibited increased	01620		

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01620	Continued From page 2 confusion and memory problems for one of six residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4's diagnoses included psychosis, bipolar, anxiety, and insomnia. R4's care plan dated June 23, 2023, indicated R4 was not a risk of elopement, had no history of elopement or wandering, and had impaired judgment due to cognitive decline. R4's assessment dated June 10, 2023, indicated R4 was independent with walking, had memory problems, asked staff to go with to the gas station and the bank, and did not leave the facility without an escort. R4's progress note dated June 11, 2023, at 2:34 p.m. indicated R4 had increased confusion for the past two days. R4's progress note dated June 12, 2023, at 1:00 p.m. indicated R4 accused staff of taking cigarettes and giving them to someone else. R4's progress note dated June 13, 2023, at 1:00 p.m. indicated R4 was removing her clothing this morning right after staff assisted her with getting dressed. The note indicated R4 became upset with the staff and after the staff let her do her own thing, she put her pants on without putting her brief on first.	01620		

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01620	Continued From page 3 R4's progress note dated June 15, 2023, at 9:39 a.m. indicated R4 was attempting to flush her underwear down the toilet. R4's progress note dated June 22, 2023, at 5:00 a.m. indicated R4 got out of bed then called staff to put her back multiple times throughout the night. The note indicated R4 was up through the night folding clothes, cleaning the counters in her room, and walking up and down the hallway; R4 also thought it was supper time in the morning. R4's progress note, dated June 23, 2023, at 1:09 p.m. indicated RN-A was made aware of staff concerns related to R4's change in behavior. The note indicated R4 has been restless lately, memory is worsening, and she is often asking staff what she should be doing. The note indicated RN-A would discuss R4's behavior with the "Psych NP." R4's progress note, dated June 23, 2023, at 9:00 p.m. indicated staff assisted R4 to bed, R4 would get up out of bed, walk into the hall, and ask staff to help her to bed. The note indicated R4 repeated this several times. R4's progress note, dated June 27, 2023, at 5:00 a.m. indicated R4 pressed her call light multiple times throughout the night shift and when staff asked what she needed, she said she did not need anything, she was just playing with the button. The note further indicated R4 was riding up and down the elevator throughout the night shift. R4's progress note, dated July 23, 2023, at 9:00 p.m. indicated R4 accused staff of taking her cigarettes. The note further indicated R4 kept	01620		

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01620	Continued From page 4 lying down on the floor in the hallway. R4's progress note, dated July 5, 2023, at 9:00 p.m. indicated R4 kept lying down on the hallway floor. The note further indicated R4 would ask to be put to bed, would get up a few minutes later and ask to be put back to bed again. R4's progress note, dated July 6, 2023, at 1:00 p.m. indicated R4 would ask to be put to bed, would get up and ask to be put back to bed again. The note further indicated R4 was moving back and forth from chair to chair constantly. R4's progress note, dated July 9, 2023, at 9:00 p.m. indicated R4 kept getting out of bed and asking to be put back to bed. The note further indicated R4 could not find her room and was wandering around first floor at 9:00 p.m. R4's progress note, dated July 11, 2023, at 9:00 p.m. indicated R4 kept lying on the hallway floor, asking to be put back to bed. R4's progress note, dated July 13, 2023, at 9:00 p.m. indicated R4 was lying on the hallway floor. R4's progress note, dated July 15, 2023, at 9:00 p.m. indicated R4 could not remember where her room was and was lying on the couch downstairs to sleep. The note further indicated R4 was assisted into her pajama's and to bed then later came out into the hallway dressed in her daily clothing asking for help to get ready for bed. R4's progress note, dated July 20, 2023, at 11:08 a.m. indicated R4 had been more confused recently. The note indicated medication adjustments were made and the medical provider would see her Monday during rounds.	01620		

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01620	Continued From page 5 R4's progress note, dated July 25, 2023, at 9:00 p.m. indicated R4 was putting her belongings in the hall saying they were not hers. R4's progress note, dated August 5, 2023, at 7:07 p.m. indicated Aitkin County Dispatch called the facility at 5:05 p.m. to notify staff R4 was out of the facility and by Block North. The note indicated at 4:20 p.m. R4 had asked RN-A if she would take her to the bank to get money for cigarettes. RN-A told R4 it was Saturday, and the bank was not open and R4 had cigarettes at the facility. R4 said she would like to go to the bank on Monday, R4 walked to the lobby area with staff and went to the bathroom. The note further indicated the facility video footage showed R4 leaving the facility at 4:23 p.m. R4's progress note, dated August 5, 2023, at 9:00 p.m. indicated R4 would go downstairs and ask staff for help to her room, staff would bring her to her room. The note indicated R4 would repeat this after staff left R4 in her room. A second note entry at 9:00 p.m. indicated R4 told unlicensed personnel (ULP)-F she wanted to go to the gas station to get cigarettes and ULP-F told her they could not go at that time. Further review of R4's record did not identify an assessment to address the resident change in needs was completed. During an interview, a family member (FM)-L stated R4 used to walk to the bank and convenient store unsupervised in the past. FM-L stated R4's memory has progressed to a point she should not be going anywhere by herself. During an interview on October 5, 2023, at 1:42	01620		

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01620	Continued From page 6 p.m., an unlicensed personnel (ULP)-F stated R4 wandered about the facility and was at risk for exiting the facility. ULP-F recalled one-time R4 was downtown, which may have been this incident, and two other times when R4 exited the facility unsupervised. ULP-F stated staff had to go out to the patio with R4 when she wanted to smoke and if she was down on first floor staff had to watch her. ULP-D stated since this incident staff do more frequent reassurance checks on R4. During an interview on October 13, 2023, at 2:38 p.m., RN-H stated R4 should have been reassessed to determine her new baseline. RN-H also stated interventions should have been implemented if her reassessment indicated. The licensee 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated resident monitoring and review must be conducted as needed based on changes in the needs of the resident.	01620		
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 three of five resident reviewed (R3, R4, and R5) was free from maltreatment. Findings include:	02360		

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02360	Continued From page 7 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		