Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326811160M
Compliance #: HL326818562C

Date Concluded: March 22, 2024

Name, Address, and County of Licensee Investigated:
River Oaks at Shady Ridge LLC
225 Shady Ridge Road NW
Hutchinson, MN 55350
McLeod County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Lisa Coil, 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 complete safety checks on the resident overnight. The resident fell, hit his head, slept on the floor, and was transferred to the emergency room in the morning.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident was independent, and his plan of care was being followed. When caregivers found the resident on the floor, emergency medical services were called, and the resident was transferred to the emergency room for treatment.

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

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia. The resident's service plan included assistance with medication administration and fall prevention. The resident's assessment indicated the resident was independent with transferring and walking, alert and oriented but had impaired decision-making and paranoia.

An incident report indicated the resident stated he was on his bed, felt dizzy, lost his balance, and fell. The same document indicated the resident said he tried getting up from the floor a couple of times and fell back down. The resident pushed his call pendent; facility staff member(s) went to check on him and found him on the floor. The report indicated the resident was to the emergency room and admitted to the hospital.

The facility's call light log indicated the resident's call pendent was pushed at 7:01 a.m. and 7:12 a.m. the morning of the incident.

The hospital records indicated the resident was diagnosed with influenza. The record indicated the resident told hospital staff he felt weak and when he tried to get out of bed he fell. The record further indicated the resident told hospital staff he hit his head on a chair, was wedged between a table and bed, and unable to get up all night.

During an interview, the resident stated he usually got up two or three times during the night to use the bathroom, and thought he fell one time he got up. The resident stated he yelled for help, but nobody came. The resident stated around 7:00 a.m. he found his call pendent and pushed the button. The resident stated it took staff an hour to get to his room to help him off the floor. The resident stated he was taken to the hospital and admitted with the flu, he denied pain, and had no broken bones.

During an interview, an unlicensed caregiver stated she answered the resident's call light around 7:00 am. The caregiver stated she found the resident lying on his back, in the middle of the floor, with his head towards the bed. The staff member stated the resident told her two different stories about the fall but kept going back to the first story. The first story was he had just fallen, and the second was he had been "buzzing" (using his call light) all night. The staff member stated the resident told her he was reaching for something and lost his balance. The staff member stated the resident was not wedged between anything when she found him.

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: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility sent the resident to the hospital.

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
	32681	A. BUILDING: _____ B. WING _____	C 02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS AT SHADY RIDGE LLC	225 SHADY RIDGE ROAD NW HUTCHINSON, MN 55350

(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 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: #HL326818562C / #HL326811160M #HL326816963C / #HL326819248M #HL326816499C / #HL326818970M On February 22, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order was issued. At the time of the complaint investigation, there were 33 residents receiving services under the provider ' s Assisted Living license. No orders are issued for HL326818562C/ #HL326811160M. The following correction order is issued for #HL326819248M and #HL326818970M, tag identification 2360.	0 000	No plan of correction is required for this tag.	
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	Continued From page 1 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 four residents reviewed (R2, R3 and R4) were 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.	02360		