Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326818970M & HL326819248M

Date Concluded: March 22, 2024

Compliance #: HL326816963C & HL326816499C

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: 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):
Allegation #1: The facility neglected resident #1 and resident #2 when the facility did not provide supervision and interventions, which resulted in resident #1 hitting resident #2.

Allegation #2: The facility neglected resident #1 and resident #3 when the facility did not provide supervision and interventions, which resulted in a verbal and physical altercation between resident #1 and resident #3.

Investigative Findings and Conclusion:
Allegation #1: The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility did not develop and implement

interventions despite multiple altercations involving resident #1 prior to the incident with resident #2.

Allegation #2: The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility did not develop and implement interventions despite multiple altercations involving resident #1 prior to the incident with resident #3.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed caregivers. The investigator contacted resident #1's guardian, resident #3's emergency contact, and law enforcement. The investigation included review of resident records, facility policies, facility incident reports, facility internal investigations, and law enforcement records. Also, the investigator observed interactions between the residents.

Resident #1
Resident #1's diagnoses included major depressive disorder, alcohol dependence, and unspecified intracranial injury. Resident #1's service plan included assistance with medication management, behavioral management, and addressing self-injurious behavior. Resident #1 was independent with use of a wheelchair.

Resident #1's assessment indicated he was alert and oriented but had impaired decision-making. The assessment indicated he had been more aggressive towards others and had multiple resident-to-resident altercations, had no intention of holding back his aggression when triggered, and showed no remorse or consideration for consequences for his actions.

Resident #2
Resident #2's diagnoses included adjustment disorder with mixed anxiety and depressed mood, personality disorder, hemiplegia (paralysis on one side of the body), and hemiparesis (weakness or the inability to move one side of the body). Resident #2 was independent with use of a wheelchair.

Resident #2's service plan included assistance with medication management, transferring, and cognitive/mental health management. Resident #2's assessment indicated he was alert and oriented but had impaired decision-making.

Resident #3
Resident #3's diagnoses included mood disorder, major depressive disorder, and psychoactive substance-induced psychotic disorder. Resident #3's service plan included assistance with medication management and management of verbal aggression. Resident #3 required escorts in wheelchair for mobility.

Resident #3's assessment indicated he had increased confusion, disorientation and had impaired decision making. The assessment indicated he had verbal aggression towards other

residents and staff. The assessment further indicated he wandered and became agitated with behaviors which escalated quickly.

The investigation included a review of the facility's incident reports involving resident #1.

Incident #1
An incident report indicated resident #1 entered another resident's room, attempted to put the resident in a head lock and pushed the resident to the floor. The same document indicated follow-up included education to resident(s) and to have staff available to intervene in altercations with residents. The document failed to identify new interventions to prevent potential abuse to other residents by resident #1.

Incident #2
The next day an incident report indicated resident #1 became upset at a staff member regarding access to cigarettes. When a second staff member approached and tried to talk to resident #1, resident #1 became more agitated. Resident #1 lunged up from his wheelchair towards the staff member(s) with his hands up as if he were going to choke the staff. The two staff were blocked in the medication room and called 911 for assistance.

The same document indicated the follow-up included separation of the resident(s), although the report itself indicated the interaction was between resident #1 and facility employees. The document failed to identify new interventions to prevent such an event from recurring.

Incident #3
Approximately two-and-a half weeks after incident #3, an incident report indicated resident #1 asked resident #2 for a cigarette and resident #2 said no. The report indicated resident #2 told staff resident #1 became agitated, struck resident #2 in the head, and stood up from his wheelchair in an aggressive manner. The same document indicated the resident was ask if he wanted to press charges and he said "yes" so law enforcement was contacted. The report failed to identify new interventions to prevent such an event from recurring.

Law enforcement report indicated resident #1 and resident #2 came across each other in the hall, resident #1 asked resident #2 for a cigarette and resident #2 said no. Resident #2 told the officer that was when resident #1 put his hands on him. Resident #2 told the officer he was going to fight resident #1 back but staff would not let him. Resident #2 told the officer he was hit in the head with a fist.

The facility internal investigation report indicated both resident's care plans and behavior plans were updated.

A review of resident #1 and resident #2 records indicated neither the care plan nor the behavior plan was updated following this incident.

Incident #4
Approximately two-and-a-half weeks after incident #3 an incident report indicated resident #1 and resident #3 were in the hallway yelling at one another, swinging hands, grabbing each other's beards, and kicked towards one another. The two residents were separated and instructed to remain on their own floors and smoke in separate areas. The report indicated resident #1 had a lengthy history of physical altercations with staff and other residents. The follow-up interventions were listed as separation of the two residents at all times and supervision when in common areas, but no specific interventions were described for the unlicensed caregivers to carry this out.

A review of resident #1's care plan did not identify updates to resident #1's care plan until after the fourth incident when new goals were added. However, the same review identified no new interventions were added to meet these goals.

In a facility video of the incident, the footage included resident #3 yelling aggressive words down the hall at resident #1. Resident #1 is heard yelling back at resident #3. The video then showed resident #1 stand from his wheelchair and walk down the hall towards resident #3. As resident #1 approached resident #3, resident #3 stood up from his wheelchair and took a few steps toward resident #1. As the two residents met, verbally aggressive words continued to be exchanged and physical contact was made multiple times by both residents.

The video showed one caregiver at the end of the hall where resident #3 was. That caregiver attempted to calm resident #3 intermittently and attempted to have resident #3 sit back down in his wheelchair at times, eventually getting him to do so. The video also showed two other caregivers enter the hallway from a stairway entry on the left, which was at the area of the physical altercation. The caregivers intermittently attempted to intervene in the altercation. At times during the video, the footage shows the caregivers step back during the altercation as though the residents may have swung a hand at them.

The facility internal investigation report indicated care plans and behavior plans were updated for both residents.

A review of resident #1 and resident #3 records indicated neither the care plan nor the behavior plan was updated following this incident.

During an interview, related to incident #2, resident #2 stated he was waiting outside the nursing room while a nurse got his medications ready. Resident #2 stated resident #1 asked the nurse for a cigarette and when the nurse did not answer him right away, resident #1 hit resident #2 in the head with a closed fist twice. Resident #2 stated he told resident #1 not to hit him again. Resident #2 stated this was the only altercation he had with resident #1 but he had seen resident #1 have an altercation with resident #3 after this incident.

During an interview regarding incident #4, an unlicensed caregiver stated resident #1 got easily upset if other residents got in his way and resident #3 was in resident #1's way. The caregiver stated she heard yelling and went to the hallway where she found resident #1 and resident #3 yelling down the hall at each other. At one point, resident #1 stood from his wheelchair and started walking down the hall towards resident #3, at which time resident #3 stood from his wheelchair too. The caregiver attempted to calm resident #3 without success, two other caregivers attempted to help calm resident #1 without success, and as the two residents were within reach of each other, a physical altercation took place. The caregiver stated the staff did not want to get in the middle and put themselves at risk, they stepped back because of concern for their safety. The caregiver stated she was nervous not knowing how the situation would end because the two residents are known to be aggressive and resident #1 had choked a caregiver in the past. The caregiver stated resident #1 was moved to a different floor but altercations happened with other residents. The caregiver stated staff were to keep an eye on the residents, but they did not document his whereabouts and the frequency of safety checks never changed.

During an interview, the nurse stated resident #1 was mobile and could get around the facility, and staff kept a close eye on him. The nurse stated her, administration staff, and the resident's case manager had conferences to discuss how to intervene with the resident's aggressive behaviors but were just stuck on what to do. The nurse stated staff members were afraid of him, he would just snap. If they called law enforcement for assistance, the resident would be calmed down by the time they arrived. The nurse stated they had changed resident #1's smoking area a couple of times to prevent altercations with other residents but could not recall other specific interventions.

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. Resident #2.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Resident #1 was transferred to a different facility.

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
McLeod County Attorney
Hutchinson City Attorney
Hutchinson Police Department

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		

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
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		