Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL342991761M
Compliance #: HL342999527C

Date Concluded: July 15, 2025

Name, Address, and County of Licensee Investigated:
River Oaks of Watertown Assisted Living
409 Jefferson Ave SW
Watertown, MN 55388
Carver County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lena Gangestad, 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 the facility did not reapproach the resident with medication after she refused it, leading to a change in her condition and subsequent hospitalization for diabetic ketoacidosis and a seizure as a result of missed medications.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined that neglect was not substantiated. The resident had a history of refusing medications since her admission. The facility notified the provider and encouraged the resident to take the medications as prescribed. A few days before her hospital admission, the nurse assessed the resident, and nothing unusual was found.

The investigator conducted interviews with providers and facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, internal investigation documentation, incident reports, staff schedules.

The resident resided in an assisted living building. The resident's diagnoses type 2 diabetes and schizophrenia. The resident's service plan included assistance with medication setup, administration and reporting concerns about medications or the persons refusal.

One day, a staff member notified the nurse to check on a resident because she could not tell whether the resident was ignoring her or acting differently. The nurse did an assessment and took vital signs, which were within normal limits. The resident answered the nurse's questions by nodding her head. The nurse added vitals checks two times a day through the weekend to keep an eye on the resident. The nurse contacted the physician the same day to ask about the alkaline phosphatase enzymes test, and the resident was referred to endocrinology.

Three days later when caregivers approached the resident, she did not respond when asked a question. The facility checked blood pressure and blood sugar were noted to be high and then called emergency services. The facility sent the resident to the hospital for further evaluation.

A review of the resident's medical record indicated the resident admitted to the facility four years ago and had a history of frequently refusing her scheduled medications. The facility's manager notified the physician and the psychiatrist about the refusals. The facility also discussed the risks of not taking her medications as scheduled with resident. Additionally, the facility reached out to the case manager to propose a rewards program to help with medication compliance. The facility directed caregivers to offer the medications to the resident at least three times before charting them as refused.

During an interview, unlicensed caregiver #1 stated she knew the resident had a history of refusing medication. The resident picked which medications she wanted to take and when she wanted to take them. She also said the resident had a history of "playing possum" and would not respond, which complicated determining how to provide her cares. A few days before her hospitalization, the resident was acting funny and did not seem herself. Caregiver #1 said she notified the nurse, and the nurse said there was nothing wrong with her at the time.

During an interview, unlicensed caregiver #2 said the resident did not take her medication for months. She said that right before the resident was sent to the hospital, the resident did not make eye contact with her, but that was just the resident's normal behavior. She said if the resident refused medication, the caregivers would try again.

During an interview, the nurse stated that the resident was refusing to take medication routinely and the medical provider was kept up to date. She was informed by staff about the resident's condition a few days before the resident was sent to the hospital, so she went in and talked to the resident. The resident responded to her, and she took vital signs, which were normal. And she directed caregivers to monitor vital signs and notify her if anything changed. The nurse stated the resident she seemed like her normal self when she spoke with her.

During an interview, the medical provider stated the facility notified her about the resident refusal and the resident also told her about it during their visits.

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: No. The resident was deceased.
Family/Responsible Party interviewed: No, attempted but did not reach.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility notified the provider and encouraged the resident to take the medications as prescribed. A few days before her hospital admission, the nurse assessed the resident, and nothing unusual was found.

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
	34299	A. BUILDING: _____ B. WING _____	C 06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS AT WATERTOWN	409 JEFFERSON AVENUE SW WATERTOWN, MN 55388

(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 On June 3, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL342992901M/HL342992661C, and #HL342991761M/HL342999527C . No correction orders are issued.	0 000		