Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL351952560M
Compliance #: HL351951686C

Date Concluded: April 30, 2024

Name, Address, and County of Licensee Investigated:
Riley Crossing Senior Living
620 Aldrich Drive
Chanhassen, MN 55317
Carver County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Lena Gangestad, 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 alleged perpetrator (AP) neglected the resident by failing to perform a toileting and safety check at 8 pm. Consequently, the resident was found on the floor with a hip fracture, requiring surgery.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP, an unlicensed caregiver, assisted the resident around 6 pm but did not return until 10 pm, when he was found on the floor. The AP did not provide the resident a toileting and safety check scheduled for 8pm. As a result of the fall, the resident sustained a hip fracture and required surgery.

The investigator conducted interviews with facility administrative staff. The investigator contacted the resident's family member. The investigation included review of the resident's

records, internal investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease. The resident's service plan included assistance of one person for toileting and routine safety check every two hours 12AM, 2AM, 4AM, 6AM, 8AM, 10AM, 12PM, 2PM, 4PM, 6PM, 8PM, 10PM. The resident's assessment indicated the resident had a history of falls and confusion.

The facility's internal investigation indicated the resident was found on the floor by the AP one evening around 10:00 PM. The resident was as unable to communicate what he was doing when he fell and denied experiencing pain at that time. However, the nurse noted a skin tear on his right forearm the next morning. A day later, the resident grimaced with any movement of the right leg. He then was sent to the hospital and diagnosed with a right hip fracture, requiring surgical repair. The internal investigation indicated the facility manager reviewed security footage from the evening of the resident's fall which showed the AP went to the resident's room around 6 pm but did not return until 10:06 pm, despite being scheduled for a check at 8 pm.

Based on the schedule on the day of the incident, the facility was fully staffed. The AP had worked at the facility for about six months and had worked with the resident multiple times in the past.

During an interview, the manager stated that the resident was found on the floor around 10:10 pm by the AP and was assisted to bed at that time. The resident had a history of falls; therefore, a toileting and safety check were scheduled for every two hours. The manager said the AP had entered the resident's room around 6 pm but did not return until 10:06 pm, thus missing the 8 pm toileting. The manager also stated that she interviewed the AP, who provided a conflicting information. According to the AP, she entered the room between 7 and 8 pm, then returned around 9 pm, and finally came back around 10 pm to find the resident already on the floor. The information contradicted the manager's observation from the camera footage. The manager stated that the resident appeared fine that night but experienced excruciating pain two days later while sitting in a chair. The physician was notified, and an X-ray was ordered. Due to the weekend, there was a delay in obtaining an X-ray. The decision was made to send the resident to the hospital, where it was discovered that he had a hip fracture and underwent surgery.

During an interview, the AP stated she fell behind with the care because on that night, there were multiple call lights on simultaneously. She could not recall the exact time she found the resident on the floor, but she said it was toward the end of her shift, around 9 or 10 pm. Additionally, she said that the last time she checked on him was around 7 pm. She peeked into his room and saw him sleeping on the recliner chair, so she decided to let him rest and proceeded with passing medications for other residents. She admitted to being behind on toileting him, acknowledging that she knew he required toileting every 2 hours, having worked

with him before. She stated that due to short staffing, she did not call for help until she found him on the floor. Furthermore, she noted that it took around 15 minutes for the agency staff to arrive and assist her.

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: Attempted but not successful.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The resident was assessed, and both the family and physician were notified. The resident was transferred to the hospital for evaluation and underwent hip surgery. An internal investigation was initiated, leading to the termination of the AP.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities
Carver County Attorney
Chanhassen City Attorney
Chanhassen Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35195	A. BUILDING: _____ B. WING _____	C 04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RILEY CROSSING SENIOR LIVING	620 ALDRICH DR CHANHASSEN, MN 55317

(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 April 3rd, 2024, the Minnesota Department of Health initiated an investigation of complaint HL351952560M/HL351951686C. The following correction order is issued, tag identification 2360.	0 000	Minnesota Department of Health is documenting 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. 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.	
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 one of one resident reviewed (R1) was free from maltreatment.	02360	No plan of correction is required for this tag.	

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02360	Continued From page 1 Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual was responsible was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		