Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL351958826M
Compliance #: HL351956424C

Date Concluded: May 2, 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: 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 he got another resident's regular food in the dining room. As a result, he aspirated, developed pneumonia, and passed away a week later.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident did gain access to food from a regular diet, this was an isolated event which had not occurred before with this resident.

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

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia and chronic pain. The resident's service plan included assistance with medication and meals. The resident was on hospice services.

One evening, the resident was in the dining room eating dinner, and it was discovered by the unlicensed caregivers he had taken the meal of other residents which was not his prescribed diet. The next morning, when an unlicensed caregiver went to wake him up for breakfast, it was observed that he was very tired and having difficulty breathing. The nursing staff assessed the resident, and hospice was updated. The resident was diagnosed with aspiration pneumonia and was prescribed two oral antibiotics at that time. Unfortunately, he passed away six days later.

According to hospice records, the resident was prescribed a pureed diet and nectar-thick liquids due to swallowing issues and aspiration pneumonia. The records also indicated that the resident found joy in food.

A review of the resident's medical record did not identify a similar incident occurring before this occasion.

During an interview, the manager stated the resident was at the table with other residents who had regular food, and he took their food when one of them left the table. The unlicensed caregivers intervened when the realized this and notified nursing. Unfortunately, he aspirated. He returned to meals after the incident but sat at a different table with people who had a similar diet order where caregivers assisted him with meals. Over the course of about a week he began to decline and passed away. Following the incident, caregivers were instructed to seat all residents with the same diet together and the facility educated all staff members through verbal huddles during mealtimes.

During an interview, a family member stated she was aware of the incident and said she did not view it as the facility's fault when the resident took his neighbor's regular food. She stated the facility provided him with the soft food as per the doctor's orders, and unfortunately, the incident occurred, contributed to his passing.

During an interview, the registered nurse stated the resident did not like pureed diet and refused to eat it. While sitting at the table, at the end of the meal, he grabbed someone else's plate and ate their meal. The nurse was notified by caregivers about this incident, and he went to assess the situation. He then arranged for the resident to sit with others who had the same dietary restrictions to reduce the risk of this recurring. The resident was under hospice care, and both the family and hospice were notified of the situation.

During an interview, an unlicensed caregiver stated the physician ordered the resident to be on a pureed diet, which he did not like. The resident sat at a table with others who had regular food and he ate some of the regular food at the table. Following the incident, he was placed with individuals who had similar diet restrictions.

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: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The family and hospice were notified of the situation, and an internal investigation was initiated. The facility provided dietary training update caregivers on dietary changes during daily huddles and review the communication plan regarding diets and liquid types which was posted in the kitchen cabinets and caregiver’s workspaces. Furthermore, the facility implemented a practice seating residents with similar diets together in the dining room to reduce the risk of recurrence of this type of incident.

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
	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 complaints #HL351958826M/HL351956424C and #HL351958544M/HL351955922C. No correction orders are issued.	0 000		