Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL359782345M
Compliance #: HL359781415C

Date Concluded: August 20, 2024

Name, Address, and County of Licensee Investigated:
RIVERS OF LIFE LLC
6700 Egan Drive
Savage, MN 55378
Scott County

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

Evaluator's Name: Julie Serbus, 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 resident fell resulting in injuries.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident did have an unwitnessed fall resulting in a fracture, the facility had followed the resident's care plan for safety checks and toileting.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of plan of care, assessments, progress notes, and Individual Abuse Prevention Plan. Also, the investigator completed an onsite visit to observe staff to resident interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included memory loss and blindness. The resident's service plan included assistance with escort to all destinations, bathing, medication administration, dressing, grooming, and toileting. The resident also needed to be cued at meals where food was located on her plate along with verbal cues regarding her surroundings. The resident's assessment indicated the resident required hands on guidance from staff.

On the day the resident fell, staff had earlier been assisting resident in her room. Resident had been diagnosed with COVID and required to remain in room. Caregivers had been in and out of the resident's room at mealtimes, medication administration times, toileting, and safety checks. At the time of the fall itself, a caregiver had been walking down the hallway to the resident's room and heard a loud noise followed by the resident yelling. The unlicensed caregiver found the resident on the floor.

The facility contacted the resident's medical provider who ordered a portable X-ray to check for fractures. The X-ray indicated there was a humerus (upper arm) fracture. The resident's family opted to have the resident sent to the hospital.

During an interview, the unlicensed caregiver stated when any resident falls, the staff members are trained to request another staff member to come assist, take a set of vitals, call the nurse (or if in the building ask the nurse to come to the area), and do not move the resident until cleared through nursing.

During an interview, the nurse stated the resident had been diagnosed with COVID and had become more restless making the resident's actions more impulsive.

During an interview, a family member stated the resident had fell at the family's home two months prior. The family member stated the resident's short-term memory had been declining but the resident wanted to be independent and complete tasks without requesting assistance from staff. The family member stated the resident knew the path in her room which was kept clear, and resident would use furniture to feel her way around her room. The family member stated the resident had been experiencing transient ischemic attacks (similar to a stroke) affecting her activities of daily living and ambulation.

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 Page 3 of 3 (2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: NA

Action taken by facility:
No action required.

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
	35978	A. BUILDING: _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS OF LIFE LLC	6700 EGAN DRIVE SAVAGE, MN 55378

(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 July 11, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL359781415C/#HL359782345M. No correction orders are issued.	0 000		