Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305372807M
Compliance #: HL305374684C

Date Concluded: March 7, 2023

Name, Address, and County of Licensee Investigated:
Riverside Assisted Living
812 East Centre Street
Royalton, MN 56373
Morrison County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Jill Hagen, RN,
Special Investigator

Finding: Not Substantiated

Nature of Visit:
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 a resident when they failed to arrange for pain management and an assessment of the resident's hip pain for two weeks. The facility refused to transfer the resident out of the bed with a lift requiring the resident to be bedridden. In addition, the facility refused to accept the resident back to the facility following a hospital visit.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. When the facility became aware of the resident's difficulty transferring due to hip pain, they arranged for evaluation by a physician of the resident's hip. The resident and family declined the medical evaluation visit until four days later when they agreed to an evaluation at a local hospital. The facility provided pain medication to the resident as she requested.

The investigator conducted interviews with facility staff members, including administrative staff. The investigation included review of the resident's medical record, emergency room

record, facility policies and procedures, incident reports, a review of services provided to residents by facility staff, and staff schedules.

The resident resided in an assisted living facility with diagnoses including a previous head injury with residual left side hemiparesis (weakness), limited mobility of the right arm due to pain, dementia, and scoliosis (sideways curvature of the spine). The resident's care plan included staff assistance completing all activities of daily living, two staff to stand/pivot transfer, and the resident used a wheelchair for all mobility. The resident's assessment indicated the resident was able to make her needs known to staff and had some forgetfulness.

The resident's medication administration record (MAR) indicated the resident was prescribed Baclofen (medication for pain and muscle spasms) 20 milligrams (mg) every day at bedtime, and 20 mg once a day as needed.

The facility's Uniform Disclosure of Assisted Living Services and Amenities form provided to the resident at admission, indicated the facility provided for resident transfers with stand-by assistance of one staff, a sit to stand lift, a sliding board, or a mechanical lift with assistance of one staff. The facility did not provide mechanical sling lifts or ceiling-lifts using two staff.

The facility progress notes indicated late one afternoon, when two staff attempted to pivot transfer the resident from a commode to bed, the resident complained of right hip pain and an inability to pivot transfer. Staff contacted a licensed nurse who arranged for the resident to have a non-emergent transport to a local hospital. When the paramedics arrived and contacted the resident's family, the resident and family declined transport to have the residents hip pain evaluated by a physician. Despite informing the resident and family the staff could no longer safely transfer the resident with a pivot transfer or sit to stand lift, the resident and family continued to decline the evaluation by a physician of the hip pain. Prior to leaving the facility that day, the paramedics transferred the resident back to bed. That evening staff administered the resident the scheduled, and as need, Baclofen for the resident's complaints of hip pain with relief.

The progress notes indicated over the next three days, the resident remained in bed and was assisted by staff with repositioning and incontinence care. On the third day, the resident requested staff to arrange for an in-house X-ray of the resident's right hip. When the resident's family were notified of the X-ray, a family member requested staff cancel the X-ray and the family would transport the resident for an evaluation with a physician within the next two days. Two hours later, the resident's family agreed to a non-emergent transfer of the resident to a local hospital for an evaluation.

The progress notes indicated following the resident's evaluation at a local hospital, the facility refused to accept the resident back from the hospital due to the resident's inability to safely transfer. Despite the facility concerns, the resident returned to the facility that same day. The resident remained in bed until eight days later when the facility arranged for the resident to be

transferred to a long-term care facility for a higher level of care. During that time, facility staff provided the resident with repositioning, incontinence care, and pain management.

Review of the resident's hospital record indicated the right hip and pelvic X-ray revealed severe right hip osteoarthritis and osteopenia (reduced bone mass) without a fracture.

During an interview, the licensed nurse stated when initially admitted to the facility, the resident transferred with a gait belt and stand by assistance of one staff. As the resident's ability to transfer declined, even using a sit to stand lift was not safe for the resident and staff. The facility did not have the ability or equipment to use a full mechanical sling lift. Even though staff were not able to transfer the resident during the resident's last week at the facility, the resident was routinely repositioned and sat on the edge of the bed for meals. Staff provided the resident with pain medication as the resident requested. The resident required a higher level of care than the facility was able to offer.

The resident stated she felt more comfortable at the nursing home where they used more up to date lifts.

A family member stated he was pleased with the care provided by the facility and the staff always kept him updated on the resident's condition.

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

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
	30537	A. BUILDING: _____ B. WING _____	C 02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE ASSISTED LIVING	812 CENTRE STREET EAST ROYALTON, MN 56373

(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 February 15, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL305374684C/#HL305372807M. No correction orders are issued.	0 000		