Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL313684982M
Compliance #: HL313681240C

Date Concluded: November 3, 2025

Name, Address, and County of Licensee Investigated:
Aviva River Bend Memory Care
30 Silver Lake Pl NW
Rochester, MN 55901
Olmsted 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 she fell five times within an eight-day period, resulting in a fractured humerus of her right arm and a compression fracture of L1.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. While the resident did fall multiple times the facility properly accessed for needs such as footwear and requested physical and occupational therapy evaluation. Falls were both witnessed, with either facility caregivers or family members present, or unwitnessed with no one present.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included a review of the resident record(s), hospital records, the internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. The investigator conducted

an onsite visit to the facility's memory care unit to observe the environment and flooring. Observation of the facility environment located in the memory care unit where the resident resided included in the common areas carpeting which gave off the appearance of a hardwood floor. The resident's room had vinyl/hardwood floor in both the bathroom and living area of her room.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, neuropathy (peripheral nerve damage to legs and feet), and history of falls. The resident's service plan included she was independent with transfers, at times resisted cares and showed poor judgment. A facility document indicated no falls within the previous three months and no impairment with gait or transfers.

On the day, the resident moved into the facility she was independent with ambulation and did not use an assistive device.

Falls Timeline

- Within two hours of admission, while walking with family member, the resident experienced a fall. The toe of her shoe grabbed into the floor causing her to fall forward. The resident did not experience injuries from this fall.

- Two days later the resident was observed walking with another resident in the dining room when the resident tripped on the carpet and fell forward. The resident did sustain a skin tear to her wrist and blood was noted at the corner of her mouth.

- On the third day, caregivers heard the resident calling out and found the resident in her room on her knees and elbows. The resident was found to have a swollen lip but refused ice to her lip or knees.

- Within an hour and a half another fall occurred which was witnessed by a caregiver. The caregiver was assisting the resident ambulate when the resident's toe of her shoe stubbed into carpet with resident falling face forward to the floor. The resident sustain bruising and a laceration above her eye and bleeding from her nose. The facility called emergency medical services, and the resident was transferred to the emergency department. The resident was admitted to the hospital for a fractured arm, shoulder injury, and injury to her L1 vertebra.

- Three days later the resident discharged from the hospital and returned to the facility with orders to always wear a sling except when showering. Upon discharge from the hospital new orders indicated pain medication as needed, a diagnosis which included history of osteoporosis with previous fractures and previous L1 compression within the past year due to a fall. The same document indicated the resident had recent multiple near-falls/stumbles since admission to facility and the resident had a narrowed almost

shuffling gait causing resident's toe of shoe to catch on carpeting putting her a risk for stumbling.

- After the resident returned from the hospital, the following morning caregivers heard the resident calling out for help. The caregiver found the resident sitting on her bathroom floor with legs folded under her. The resident was transferred back to the emergency department. The hospital records indicated the medical care provided at the emergency departed listed in the history and physical the resident has a history, or tremors described as "tightening up" which may contribute to falls. This same history and physical indicated a fall that had occurred both at home and at the facility.

During an interview, a nurse stated the preadmission assessment was completed at the hospital as resident's dementia has advanced and unable to care for at home. At the time of the assessment in the hospital, family was not present. The nurse stated on the day of admission family members accompanied the resident and was then able to provide some information. Upon admission, the family reported resident did not use a walker or cane and the nurse observed the resident transferring independently. When falls occurred, the nurse stated it appeared to be caused by the resident not picking up her feet enough, walking on her toes, and toe of shoe catching on flooring. The nurse stated the flooring in the resident's room was different than in the common areas. The resident transferred herself on her own, sometimes barefoot in the early morning, and wandered in the facility. The nurse caregivers offered to walk with her, however at times resident refused. Falls happened at times even when the resident was being assisted while at other times were unwitnessed. The facility team frequently discussed the falls and interventions to reduce her risk.

During an interview, a manager stated in the common and main areas of the memory care unit the carpet is designed to look like a hardwood floor and is a very tight weave with very little pile. The manager stated as resident rooms were being remodeled carpet was being removed and replaced with hardwood and that the resident's room had hardwood floor, not carpet. The manager stated the falls both in her room where there was no carpeting and in the common area where there was carpet. Due to a power outage cameras located in the common areas were not working at the time the resident resided at the facility. The manager stated nursing did consider the resident's shoes and felt they were a good fit, but that she even had falls with bare feet. The manager stated the facility did not provide 1:1 staffing any resident as caregivers must attend to other residents too.

During an interview, a family member stated resident did not use a cane or walker. The family member stated the resident was getting more difficult to care for at home, refusing medications and care at times. While the facility discussed starting physical and occupational therapy but never initiated as resident started falling immediately and was in and out of hospital.

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: deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: NA

Action taken by facility: Nursing reassessed to include review of footwear, ambulate assistance as needed, and reviewing environment hazards.

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
	31368	A. BUILDING: _____ B. WING _____	C 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(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 August 25, 2025, through August 26, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL313681240C/#HL313684982M. No correction orders are issued.	0 000		