Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL318846332M
Compliance #: HL318849580C

Date Concluded: December 13, 2024

Name, Address, and County of Licensee Investigated:
River Oaks on Lake Pepin
815 N high Street
Lake City, MN 55041
Wabasha County

Facility Type: Assisted Living Facility (ALF)

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 fell and was found on the bathroom floor with a left fibula (leg) fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined that neglect was not substantiated. Although the resident fell and sustained a left fibula fracture the facility had appropriate interventions in place and sought cares promptly when it the injury occurred.

The investigator conducted interviews with administrative staff and the resident. The investigation included review of the resident's records, incident reports, staff schedules, policies, and procedures.

The resident resided in an assisted living facility. The resident's diagnoses include anxiety disorder and diabetic neuropathy. The resident's service plan included assistance with gathering

supplies for a shower every Monday and Thursday. The service plan also indicated that the resident used a wheelchair and transferred independently.

The progress notes indicated the resident was found on the shower floor by a staff member one morning around 7:30 a.m. A post-fall assessment was conducted, and no concerns were identified.

Later the same day, the progress notes also indicated the resident complained of dizziness and had dark urine later that day. As a result, the facility transferred to resident transfer to the hospital around 11:30 p.m.

The hospital records indicated the resident admitted following a syncopal (similar to fainting) event which occurred while he was taking a shower. While in the emergency room, an X-ray revealed a non-displaced fracture of his fibular head. The intervention included placing the resident in an ACE wrap. The physician recommended working with a physical therapist so the resident could place weight on his right leg and use it as a pivot instead of the left while it healed.

During an interview, the resident stated that he was taking a shower as he usually did. He stood up, felt lightheaded, and passed out. He said it was the first time this had happened and expressed no concerns about the care he received at the facility.

During an interview, a manager, who is also nurse, stated a staff member reported the resident experienced syncope, causing him to fall in the shower. The manager stated the care plan indicated the facility was to provide assistance with gathering supplies and assisting him in and out of the shower. The manager stated this was the first time he had fallen at the facility and, after the resident returned from the hospital, the facility updated the service plan accordingly.

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: No, attempted but did not reach.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility conducted the post fall assessment and sent the hospital for further evaluation.

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
	31884	A. BUILDING: _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS AT LAKE PEPIN LLC	815 NORTH HIGH STREET LAKE CITY, MN 55041

(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 November 21, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL318846332M/HL318849580C. No correction orders are issued.	0 000		