Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326497424M
Compliance #: HL326494012C

Date Concluded:

Name, Address, and County of Licensee Investigated:
Rivers Edge Assisted Living
11 Minnesota Avenue South
Aitkin, MN 56431
Aitkin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Lisa Coil, 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 facility failed to provide supervision to prevent and altercation between two residents. The altercation resulted in resident #1 being punched in the arm, having two fingers squeezed and his hand bent back.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. While the altercation did occur, resident #1 did not sustain serious harm and staff members had taken steps to prevent it and the residents care plans were followed.

The investigator conducted interviews with facility staff members, including a member of management and unlicensed staff. The investigator interviewed the residents and the resident's family member. The investigation included a review of resident #1 and resident #2's medical records. Also, the investigator toured the facility, and observed interactions between resident #1 and resident #2.

Resident #1 resided in an assisted living facility. The resident's diagnoses included Alzheimer's. The resident's assessments indicated he had impaired memory, was disoriented to time and place, and his wife yelled and argued with him.

Resident #2 resided in an assisted living facility. The resident's diagnoses included dementia and spinal stenosis. The resident's assessments indicated she used a wheelchair and was verbally aggressive with her spouse at times.

An incident report indicated resident #2 hit resident #1 with a closed fist in the upper chest area, tore a napkin from resident #1's hand, and placed it on the table. The report indicated resident #1 reached for the napkin and resident #2 grabbed two of resident #1's fingers and bent them backwards. Resident #1 said "ouch" and resident #2 let go of resident #1's fingers. Resident #1's record indicated there was no bruising or injury following the incident.

During an interview, resident #2 stated resident #1 moved to a different room once before because staff thought she was yelling at him. Resident #2 stated the move did not work out because resident #1 wanted to move back in with resident #1. Resident #2 denied yelling at resident #1 and stated resident #1 was hard of hearing. Resident #2 denied concerns between her and resident #1.

During an interview, the resident's family member stated resident #1 and resident #2 have been by each other sides their entire lives; they worked together and retired together. The family member stated the facility separated the two residents but resident #1 was uncontrollable until staff moved him back in with resident #2. The family member stated he does not feel like resident #1 is at serious risk for injury by resident #1 and separating the two of them makes the situation worse.

During an interview, an unlicensed staff member stated there are incidents like this between resident #1 and resident #2 during meals because resident #2 will take things away from resident #1. An example the unlicensed staff member stated was when resident #1 tries to eat dessert first, resident #1 will move it away because you should not eat dessert first; or if resident #1 is messing around with a napkin, resident #2 will take it and move it out of reach. The unlicensed staff member stated she has not seen any injuries occur to either resident during this or any other altercation.

During an interview, a member of management stated they are working with the family to make alternative living arrangements to meet the needs of both residents. In the meantime, staff are sitting at the table with resident #1 and resident #2 during meals.

In conclusion, the Minnesota Department of Health determined abuse 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
	32649	A. BUILDING: _____ B. WING _____	C 08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE ASSISTED LIVING	11 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL326497424M / #HL326494012C #HL326497425M / #HL326494013C #HL326497785M / #HL326494593C #HL326497806M / #HL326494616C #HL326497807M / #HL326494617C On August 22 and August 23, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 33 residents receiving services under the provider's Assisted Living license. The following correction order is issued for: #HL326497425M / #HL326494013C, tag identification 2360 #HL326497785M / #HL326494593C, tag	0 000	The Minnesota Department of Health documents the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the Surveyors and/or Investigators ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the state correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys and/or complaint investigations. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.	

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0 000	Continued From page 1 identification 2360 #HL326497806M / #HL326494616C, tag identification 1620 and 2360.	0 000	THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPY AND LEVEL ISSUED PURSUANT TO THE MINN. STAT. § 144G.31, SUBDIVISION 2 and 3.	
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on document review, and interview the licensee failed to reassess and monitor change in needs when the resident exhibited increased	01620		

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01620	Continued From page 2 confusion and memory problems for one of six residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4's diagnoses included psychosis, bipolar, anxiety, and insomnia. R4's care plan dated June 23, 2023, indicated R4 was not a risk of elopement, had no history of elopement or wandering, and had impaired judgment due to cognitive decline. R4's assessment dated June 10, 2023, indicated R4 was independent with walking, had memory problems, asked staff to go with to the gas station and the bank, and did not leave the facility without an escort. R4's progress note dated June 11, 2023, at 2:34 p.m. indicated R4 had increased confusion for the past two days. R4's progress note dated June 12, 2023, at 1:00 p.m. indicated R4 accused staff of taking cigarettes and giving them to someone else. R4's progress note dated June 13, 2023, at 1:00 p.m. indicated R4 was removing her clothing this morning right after staff assisted her with getting dressed. The note indicated R4 became upset with the staff and after the staff let her do her own thing, she put her pants on without putting her brief on first.	01620		

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01620	Continued From page 3 R4's progress note dated June 15, 2023, at 9:39 a.m. indicated R4 was attempting to flush her underwear down the toilet. R4's progress note dated June 22, 2023, at 5:00 a.m. indicated R4 got out of bed then called staff to put her back multiple times throughout the night. The note indicated R4 was up through the night folding clothes, cleaning the counters in her room, and walking up and down the hallway; R4 also thought it was supper time in the morning. R4's progress note, dated June 23, 2023, at 1:09 p.m. indicated RN-A was made aware of staff concerns related to R4's change in behavior. The note indicated R4 has been restless lately, memory is worsening, and she is often asking staff what she should be doing. The note indicated RN-A would discuss R4's behavior with the "Psych NP." R4's progress note, dated June 23, 2023, at 9:00 p.m. indicated staff assisted R4 to bed, R4 would get up out of bed, walk into the hall, and ask staff to help her to bed. The note indicated R4 repeated this several times. R4's progress note, dated June 27, 2023, at 5:00 a.m. indicated R4 pressed her call light multiple times throughout the night shift and when staff asked what she needed, she said she did not need anything, she was just playing with the button. The note further indicated R4 was riding up and down the elevator throughout the night shift. R4's progress note, dated July 23, 2023, at 9:00 p.m. indicated R4 accused staff of taking her cigarettes. The note further indicated R4 kept	01620		

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01620	Continued From page 4 lying down on the floor in the hallway. R4's progress note, dated July 5, 2023, at 9:00 p.m. indicated R4 kept lying down on the hallway floor. The note further indicated R4 would ask to be put to bed, would get up a few minutes later and ask to be put back to bed again. R4's progress note, dated July 6, 2023, at 1:00 p.m. indicated R4 would ask to be put to bed, would get up and ask to be put back to bed again. The note further indicated R4 was moving back and forth from chair to chair constantly. R4's progress note, dated July 9, 2023, at 9:00 p.m. indicated R4 kept getting out of bed and asking to be put back to bed. The note further indicated R4 could not find her room and was wandering around first floor at 9:00 p.m. R4's progress note, dated July 11, 2023, at 9:00 p.m. indicated R4 kept lying on the hallway floor, asking to be put back to bed. R4's progress note, dated July 13, 2023, at 9:00 p.m. indicated R4 was lying on the hallway floor. R4's progress note, dated July 15, 2023, at 9:00 p.m. indicated R4 could not remember where her room was and was lying on the couch downstairs to sleep. The note further indicated R4 was assisted into her pajama's and to bed then later came out into the hallway dressed in her daily clothing asking for help to get ready for bed. R4's progress note, dated July 20, 2023, at 11:08 a.m. indicated R4 had been more confused recently. The note indicated medication adjustments were made and the medical provider would see her Monday during rounds.	01620		

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01620	Continued From page 5 R4's progress note, dated July 25, 2023, at 9:00 p.m. indicated R4 was putting her belongings in the hall saying they were not hers. R4's progress note, dated August 5, 2023, at 7:07 p.m. indicated Aitkin County Dispatch called the facility at 5:05 p.m. to notify staff R4 was out of the facility and by Block North. The note indicated at 4:20 p.m. R4 had asked RN-A if she would take her to the bank to get money for cigarettes. RN-A told R4 it was Saturday, and the bank was not open and R4 had cigarettes at the facility. R4 said she would like to go to the bank on Monday, R4 walked to the lobby area with staff and went to the bathroom. The note further indicated the facility video footage showed R4 leaving the facility at 4:23 p.m. R4's progress note, dated August 5, 2023, at 9:00 p.m. indicated R4 would go downstairs and ask staff for help to her room, staff would bring her to her room. The note indicated R4 would repeat this after staff left R4 in her room. A second note entry at 9:00 p.m. indicated R4 told unlicensed personnel (ULP)-F she wanted to go to the gas station to get cigarettes and ULP-F told her they could not go at that time. Further review of R4's record did not identify an assessment to address the resident change in needs was completed. During an interview, a family member (FM)-L stated R4 used to walk to the bank and convenient store unsupervised in the past. FM-L stated R4's memory has progressed to a point she should not be going anywhere by herself. During an interview on October 5, 2023, at 1:42	01620		

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01620	Continued From page 6 p.m., an unlicensed personnel (ULP)-F stated R4 wandered about the facility and was at risk for exiting the facility. ULP-F recalled one-time R4 was downtown, which may have been this incident, and two other times when R4 exited the facility unsupervised. ULP-F stated staff had to go out to the patio with R4 when she wanted to smoke and if she was down on first floor staff had to watch her. ULP-D stated since this incident staff do more frequent reassurance checks on R4. During an interview on October 13, 2023, at 2:38 p.m., RN-H stated R4 should have been reassessed to determine her new baseline. RN-H also stated interventions should have been implemented if her reassessment indicated. The licensee 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated resident monitoring and review must be conducted as needed based on changes in the needs of the resident.	01620		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure three of five resident reviewed (R3, R4, and R5) was free from maltreatment. Findings include:	02360		

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02360	Continued From page 7 The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		