Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL313683222M
Compliance #: HL313683300C

Date Concluded: August 25, 2024

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: Deb Schillinger RN, Special Investigator

Finding: Substantiated, individual responsibility

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 alleged perpetrator (AP), a facility unlicensed caregiver, abused the resident when the AP placed a restraint on the resident while in her Broda chair.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP, an unlicensed caregiver, was responsible for the maltreatment. The AP intentionally secured a gait belt on the resident restraining her in a Broda chair causing unreasonable confinement.

The investigator conducted interviews with facility staff members, including management staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures Also, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease. The resident's service plan included assistance with safety checks and redirection as needed. The resident's assessment indicated the resident was disoriented, had frequent anxiety, and had chronic pain. The resident required hands-on assistance for transferring and needed assistive devices for mobility and ambulation. The resident did have a history of falls and used a Broda chair (a wheelchair designed to prevent pressure sores, falls, slumping, and sliding out of the chair). The resident was enrolled in hospice.

One day, the resident was found by a family member with a gait belt around her while seated in a Broda chair. The family member notified unlicensed caregivers, the gait belt was immediately removed, and no injuries were noted.

During an interview, a manager stated during the internal investigation the AP stated she placed the gait belt on the resident because the resident was leaning, and the AP thought she would fall forward out of the chair, so she placed a gait belt around the resident's waist to keep her safe. The manager stated the AP said she had not tried other interventions before placing the gait belt on the resident. The manager reiterated the AP was trained upon hire two months before the incident the facility was "zero tolerance" restraint free facility. The AP's employment was then terminated.

During an interview, unlicensed caregiver #1 stated the family member notified her the resident had a gait belt around her in the Broda chair. Unlicensed caregiver #1 immediately removed the gait belt, transferred her to a recliner, and observed the resident had no injuries. Unlicensed caregiver #1 stated she was not aware of the AP ever using a gait belt as a restraint before and did not work with the AP after that day. Unlicensed caregiver #1 reported additional training was provided to all staff regarding restraints abuse and vulnerable adult reporting after the incident.

During an interview, unlicensed caregiver #2 stated after the family member notified unlicensed caregivers, the resident was found with the gait belt around the resident's waist and secured in the back where the resident could not remove the gait belt. Unlicensed caregiver #2 stated she saw the AP grab her things and walk out the door, leaving without giving report or completing walking rounds which was normal practice at the facility.

During an interview, the AP indicated she was mandated to stay and work a twelve-hour shift. The AP stated she was trying to provide care to other residents and the resident was leaning forward and was afraid the resident would fall forward out of the chair and hurt herself, so she placed a gait belt around the resident in the chair to prevent her falling forward out of the Broda chair. The AP stated she did not try other interventions before placing the gait belt around the resident's waist. The AP stated she did not secure the belt but placed it as a reminder for the resident to not lean forward in the Broda chair. The AP stated she alerted her coworkers the gait belt was on the resident when her shift was over, however the AP could not remember the staff member's name.

During an interview, the family member reported they found the resident in a common area sitting in her Broda chair with a belt around her waist that was secured in a way the resident could not have removed independently. The family member notified the unlicensed caregivers who removed the belt as soon as it was brought to their attention, assessed the resident for injuries, and there were none. The family member stated they had not seen a restraint used in the facility before that incident nor since.

In conclusion, the Minnesota Department of Health determined abuse was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult.

Vulnerable Adult interviewed: No, attempted but unable due to cognitive impairment.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:

The facility terminated employment the AP's employment. The facility provided re-training provided to all staff on preventing abuse and its policy regarding restraining residents.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Olmsted County Attorney
Rochester City Attorney
Rochester Police Department
Minnesota Department of Human Services - Licensing

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 07/11/2024

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 ******ATTENTION****** ASSISTED LIVING PROVIDER 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: #HL313683300C/#HL313683222M On July 11, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 74 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL313683300C/#HL313683222M, tag identification 2360.	0 000	Minnesota Department of Health is documenting 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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 one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	