Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL218713506M
Compliance #: HL218712902C

Date Concluded: October 12, 2026

Name, Address, and County of Licensee Investigated:
River Oaks of Minnesota
900 42nd Ave NE
Columbia Heights, MN 55421
Ramsey County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name:
Lacey Eggersdorfer, RN, Special Investigator

Finding: Substantiated, facility 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 facility neglected the resident when the nurse was not notified of the resident's head injury after a fall, resulting in a delay in the resident's evaluation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility failed to implement a formal system for unlicensed staff and nurses to assess residents, document their findings, and recommend appropriate interventions following a concern. The failure led to critical information regarding the resident's head injury and blood thinning medication being missed, resulting in a delay in the resident's transport to the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, death record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with managing physical aggression as well as orientation to his environment. The resident's assessment indicated he was confused and needed minor assistance with transferring.

An incident report indicated the resident fell on the night shift while trying to stand up from a recliner. The resident had injuries to his head and skin tears to both arms. Contributing factors were listed as agitation and weakness. The incident report indicated unlicensed staff called the nurse who instructed them to administer an as needed pain medication to the resident.

Progress notes indicated unlicensed staff witnessed the resident fall and documented injuries to his head and arms. The next day, a manager had the resident transported to the hospital after they recognized the resident was on blood thinning medication (a medication that prevents blood clots, however, can cause bleeding after traumatic head injury). Progress notes indicated the on call nurse was called by unlicensed staff but was not informed of the resident's head injury or blood thinning medication.

Medical records indicated when the resident arrived at the hospital, he was minimally responsive. The resident was diagnosed with a fractured nose and bruising to both eyes. A medical provider noted a concern regarding the care at the facility.

Messages from the on call nurse to other licensed facility staff the morning after the incident indicated she had received a call from the facility after the resident fell on the overnight shift but was confused about what resident had fallen and what the concern was. The on call nurse reported to the licensed facility staff that the resident's fall was unwitnessed, and he had sustained no injuries. Messages from the on call nurse to other licensed staff did not indicate she was informed about the resident's medications, condition, or vital signs.

In an interview, nurse management stated documentation for when residents go to the hospital was only done through messages between nursing staff. There was no expectation for nurses to ask if a resident is on blood thinning medication after a fall. Nurse management stated while it was expected unlicensed staff take vitals, assess for injuries and changes in condition prior to calling the nurse, it was not expected that these findings be documented anywhere by unlicensed staff.

In an interview, unlicensed staff #1 stated the resident had been agitated and weak during the night. She witnessed him attempt to stand from a recliner chair, and he fell before she could get to him to assist in him standing. Unlicensed staff #1 stated she believed the resident needed hospital evaluation due to his weak, agitated condition and the fall.

In an interview, unlicensed staff #2 stated she was informed the resident had fallen and went to assist unlicensed staff #1. She instructed unlicensed staff #1 to take the residents vital signs

while she called the nurse who was on call for the facility. She informed the nurse the resident had been weak and agitated all night, and that he had fallen and his head was bleeding. She denied the nurse asking her any questions about the resident's medical history or about his medications. Unlicensed staff #2 stated the nurse did not recommend transport to the hospital.

In an interview, the nurse stated she was on call the night the resident fell but did not recall the conversation with unlicensed staff #2. She would not have known the resident or if he was on blood thinning medication because nurses were not required by the facility to check resident charts when they are called by unlicensed staff. She stated the facility does not require formal charting on a resident when they receive a call. She wrote short notes on her phone, and sent her message update the next morning to other licensed staff about the calls she received.

In an interview, a family member of the resident stated his hospitalization for his injuries after the fall was very stressful. The family member also stated the resident's care team had brought up concerns about him returning to the facility.

The resident was unable to be interviewed as he passed away shortly after the incident from natural causes.

In conclusion, the Minnesota Department of Health determined neglect 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.

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: No, resident deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The resident was sent to the hospital the next day for evaluation.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney
Columbia Heights City Attorney
Columbia Heights Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21871	A. BUILDING: _____ B. WING _____	C 09/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS COLUMBIA HEIGHTS	900 42ND AVENUE NE COLUMBIA HEIGHTS, MN 55421

(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: HL218712902C/#HL218713506M On September 1, 2026, 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 64 residents receiving services under the provider ' s Assisted Living with Dementia Care license.	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	

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0 000	Continued From page 1 The following correction order is issued/orders are issued for HL218712902C/#HL218713506M, tag identification 2360.	0 000	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, 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 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		