Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL359785242M
Compliance #: HL359781882C

Date Concluded: November 12, 2025

Name, Address, and County of Licensee Investigated:
Rivers of Life
6700 Egan Drive
Savage, MN 55378
Scott County

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

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 the resident woke up with swelling, bruising, and dried blood on forehead.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The cause of the resident's injuries remained unknown and there was no unwitnessed falls. The facility took appropriate steps to update the medical provider and seek care when the injuries were identified.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigation included review of the resident's records, internal investigation documentation, incident reports, staff schedules, policies, and procedures.

The resident lived in an assisted living secured memory care building. The resident's diagnoses included dementia without behavioral disturbance. The service plan indicated that the resident required assistance with some activities of daily living and medication administration. It also

included safety checks every two hours during the night. The resident's assessment indicated he was independent with transfers and mobility.

A concern arose when the resident was found with swelling, bruising, and dried blood on his forehead however the resident was unable to tell the caregiver what had happened. A notification was sent to the provider regarding the abrasion, and the medical provider ordered the facility to monitor for any neurological changes and to update as needed.

The following day, the progress notes indicated the resident came to the dining room with the same bump on the forehead and a new bump on the back of the head although the cause was unknown. The note also indicated the caregiver observed the resident behaving differently than usual as he was unable to engage in conversation as he normally would, although he was alert, sitting in a chair, and showed no signs of pain or discomfort. The facility obtained vital signs and, while those were normal limits, emergency services were called, and the resident was transferred to the hospital for further evaluation.

During an interview, a manager, who was also a nurse, stated the resident walked miles every day, was very active, and, if he did fall, could get up himself and continue walking. He walked without using any assistive device. The manager said there was no documentation of a fall, so she did not know when or how he sustained the wound on his forehead. Caregivers had conducted safety checks every two hours at night, starting at midnight, and confirmed he was in bed both nights.

During an interview, an unlicensed caregiver stated the resident was very mobile, walking everywhere but returning for mealtimes. The caregivers stated she was the one who found him with swelling, bruising, and dried blood on his forehead so she took images and provided them to the nurse. The resident continued his day as usual, eating breakfast and lunch. She said it was difficult to determine what had happened since he often walked independently and could get up by himself and she had not witnessed a fall.

During an interview, a family member stated they were happy with the care provided by the facility and confirmed the facility called to notify them about the incident. Unfortunately, the family member said the resident passed away a week after being admitted to the 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: No. The resident was deceased.
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
	35978	A. BUILDING: _____ B. WING _____	C 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS OF LIFE LLC	6700 EGAN DRIVE SAVAGE, MN 55378

(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 September 11, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL359785242M/HL359781882C. No correction orders are issued.	0 000		