Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL21518002M
Compliance #: HL21518003C

Date Concluded: February 7, 2023

Name, Address, and County of Licensee Investigated:
Harmony Place
455 Main Avenue North
Harmony, MN 55939
Fillmore County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Zalei Lewis, RN
Special Investigator

Carrie Euerle, MSN, RN

Finding: Inconclusive

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 they failed to assess a resident's change in condition and failed to notify the resident's physician of the observed change.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. There is not enough evidence available to support if the resident had an observed change in condition, and staff who worked at the time of the incident were not available for interview.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident medical records, facility records, policies, and procedures. At the time of the onsite visit, the

investigator completed observations of the environment, staff interaction with residents, and cares provided at the facility.

The resident resided in an assisted living with dementia care facility. The resident's diagnoses included dementia and Parkinson's disease. The resident's service plan included assistance with activities of daily living, medication management, and behavior monitoring. The resident's assessment indicated the resident could communicate verbally, had trouble with word finding, required staff to provide cues, reminders, redirection, and assistance with completion of daily cares.

An alleged incident occurred where a change in condition of the resident was observed by unlicensed staff (ULP)s that included the resident vomiting and having vital signs outside normal limits. The ULPs contacted the facility nurse who told the ULPs to "push water and check her [the resident] in the morning". The nurse provided no further direction or guidance and did not assess the resident.

Review of the resident's medical record included no documentation of this incident. There was no documentation of the resident's vital signs being outside of normal limits, the resident vomiting, contact with the facility nurse, or any other noted change in condition identified within the resident's medical record or facility reports. Further review of the resident's record included documentation of multiple incidents around the same time where noted changes in condition where observed and staff responded with assessment of the resident and having the resident sent to the hospital for further evaluation.

Attempts to interview staff who worked at the facility at the time the alleged incident occurred were unsuccessful. The facility nurse who worked at the time of this alleged incident declined to be interviewed.

Investigative interviews that were completed were unable to identify any current staff that were familiar with the alleged incident.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
None.

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
	21518	A. BUILDING: _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

(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 1, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL21518003C/HL21518002M and HL21518005C/HL21518004M. No correction orders are issued.	0 000		