Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL21518004M
Compliance #: HL21518005C

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 staff failed to notify the resident's physician of a fall, resulting in a delay of care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Due to conflicting information and lack of documentation, it is unable to be determined if staff failed to immediately notify the physician and if this resulted in a delay in care. However, when the resident sustained a fall with possible head injury, facility staff assessed and monitored the resident's condition. The family was notified who declined to have the resident sent to the hospital for evaluation. Two days later, when a change in condition was observed, the resident was sent to the hospital. The resident was admitted and later discharged on hospice services.

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. Also, the investigator observed staff interaction and provision of cares during the onsite investigation.

The resident resided in an assisted living with dementia care facility. The resident's diagnoses included dementia, diabetes type 2, atrial fibrillation, and a history of falls. The resident's service plan included assistance with activities of daily living, medication management, and safety checks twice per hour. The resident's assessment indicated the resident could communicate verbally, had trouble with word finding, a history of wandering, and required staff to provide cues, reminders, redirection, and assistance with completion of daily cares.

The day the incident occurred, the resident was found on floor in his bathroom, lying on his right side. The resident could not report the cause of the fall. Staff assisted the resident up to a seated position, obtained a set of vital signs, and assessed the resident for injury. A minor abrasion was observed on the top of the resident's head, with no signs of bleeding or further injury. Staff were directed to monitor for any further signs of bleeding, change in condition, change in mental status or cognition, and report any observed changes to the nurse.

Investigative interviews identified that the resident's family was notified of the fall and declined to have the resident sent to the hospital for an evaluation. Staff continued to monitor the resident and when a change in condition was observed, the resident was sent for further evaluation and admitted to the hospital. The nurse working at the time of the incident declined to be interviewed.

There was a lack of documentation of the frequency of nursing assessments and monitoring of the resident's condition from the time of the fall to the day the resident was sent to the hospital. In addition, there was no documentation available to support or identify if the resident's physician was notified immediately of the fall or if the physician was notified of the resident being sent to the hospital with an observed change in condition. It is unable to be determined if physician notification would have altered the outcome or care provided to the resident.

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		