Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL394851640M
Compliance #: HL394859223C

Date Concluded: July 25, 2024

Name, Address, and County of Licensee Investigated:
Harmony Gardens
1440 County Road C East 109
Maplewood, MN 55109
Ramsey County

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

Evaluator's Name: Lori Pokela, 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):
Facility staff neglected the resident when they did not toilet the resident as indicated on the service plan and the resident fell and sustained a right hip fracture and head injury.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell and sustained a hip fracture, the resident was independent with mobility and fell during an independent transfer to the bathroom. Following the fall, staff assisted the resident off of the floor and attempted to contact the facility nurse. When a change in condition was later observed, the resident was transferred to the hospital for further evaluation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's record, facility internal investigation documentation, facility incident reports, personnel files, staff

schedules, and related facility policies and procedures. Also, the investigator observed the facility, the resident's room, and staff to resident interactions.

The resident resided in an assisted living memory care unit with a diagnosis of dementia. The resident's service plan included reassurance checks, medication management, and toileting assistance. The resident's assessment indicated the resident was cognitively impaired and had a history of falls. The assessment further indicated the resident was independent with mobility and noted that the resident independently wandered throughout the unit with a four-wheeled walker and required reminders and standby assistance with toileting.

The resident's medical record indicated the resident was found on the floor in her bathroom at the end of an evening shift. Staff attempted to contact the on-call nurse; the nurse did not answer, and staff left a message about the fall. Staff assisted the resident off the floor and noted that the resident complained of knee pain but was able to walk back to bed with assistance.

The on-call nurse spoke with facility staff later that night and documented on the fall. The nurse directed staff to increase safety checks and updated the resident's family about the fall. The on-call nurse documented again around 5:30 a.m. that night shift staff completed safety checks and obtained vital signs. The nurse documented that the resident reported mild hip pain, had no change in gait with ambulation, and staff administered Tylenol for pain.

Later that morning, the resident refused to get out of bed and complained of excruciating right hip pain. A facility nurse assessed the resident, contacted nurse management and the resident's family, and transported the resident to the hospital for further evaluation. The resident was diagnosed with a right hip fracture and urinary tract infection (UTI).

During an interview, the on-call nurse stated staff initially reported that the resident was found on floor, sustained no injuries, and had no complaints of pain. The on-call nurse instructed staff to continue safety checks, report any change in condition, and for the facility nurse to follow-up with the resident the next day.

During an interview, nursing staff stated when unlicensed staff reported the resident refused to get out of bed due to leg pain, they completed an assessment and found the resident was unable to move her right leg. Nursing management and the resident's family were notified, and the resident was sent to the hospital for further evaluation.

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, due to cognitive impairment.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Attempts to contact were not successful.

Action taken by facility:
The facility completed an investigation into the fall and completed staff education regarding incident reporting and on-call nurse protocol following the incident.

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
	39485	A. BUILDING: _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY GARDENS	1440 COUNTY ROAD C EAST MAPLEWOOD, MN 55109

(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 May 23, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL394859223C/#HL394851640M. No correction orders are issued.	0 000		