

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL285227443M
Compliance #: HL285222821C

Date Concluded: February 7, 2025

Name, Address, and County of Licensee

Investigated:

The Harbor at Peace Village
300 Faxon Road North
Norwood Young America, MN 55368
Carver 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 she was found confused and sent to the emergency room (ER), where she tested positive for fentanyl and was administered Narcan.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined that neglect was not substantiated. Although the resident was found to have fentanyl in her system, there was no evidence indicating the facility gave nor administered fentanyl. No residents at the facility had a prescription for fentanyl and the facility had none in its medical supplies.

The investigator conducted interviews with facility staff members, including administrative 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 resided in an assisted living secured memory care building. The resident's diagnoses include cognitive impairment and chronic low back pain. The resident's service plan included medication management.

On a Monday, the progress notes indicated the resident experienced increased confusion and complained of frequent and urgent urination. The facility contacted the physician, who ordered a urinalysis (UA) with a reflex culture (UC). Two days later, the results came back and indicating a possible infection, and the physician prescribed Macrobid (an antibiotic) by mouth twice a day for seven days.

On Thursday, the progress notes indicated that the resident was sent to the emergency room (ER) due to increasing lower back pain following an unwitnessed fall.

The hospital records indicated that the resident initially presented with complaints of back pain but was later found to be confused in the ER and subsequently developed a fever. She appeared drowsy but was arousable. A routine urine drug screen was conducted, which tested positive for fentanyl. The hospital checked the resident for a fentanyl patch, but none was found. Fentanyl was not listed in her prescribed medications, nor was she administered any by paramedics. As a precaution and given these findings, the hospital administered a dose of Narcan.

The hospital records also indicated Macrobid could have contributed to her confusion.

During an interview, a manager, who was also nurse, stated the resident experienced a fall and was very confused when the lift assist team arrived to help her up. The manager stated the resident was unable to explain what had happened. Due to what appeared to be a change in her condition the resident was transported to the emergency room (ER). In the ER, a nurse reported that the resident tested positive for fentanyl.

The manager initiated an internal investigation but was unable to determine how the resident had fentanyl in her system. She confirmed that the resident did not have an order for fentanyl and the facility managed her medications. Additionally, no other residents under the facility's medication management had orders for fentanyl.

During an interview, the resident was unable to recall what had happened but stated that she loved being at the facility and had no concerns about the care she received.

During an interview, the resident's family stated none of her family visitors used fentanyl and it was unknown how the resident would have been exposed to fentanyl.

In conclusion, the Minnesota Department of Health determined that 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: Yes.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility started an internal investigation.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28522	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/23/2025
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NAME OF PROVIDER OR SUPPLIER THE HARBOR AT PEACE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 300 FAXON ROAD NORTH NORWOOD YOUNG AMERIC, MN 55368
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(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	<p>Initial Comments</p> <p>On January 23, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL285227443M/ HL285222821C . No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____