Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL329916506M
Compliance #: HL329912238C

Date Concluded: December 22, 2023

Name, Address, and County of Licensee Investigated:
Harbor Crossing
4650 Centerville Rd
White Bear Lake MN 55127
Ramsey County

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

Evaluator's Name: Maggie Regnier, 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 facility did not provide overnight cares resulting in a fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While resident was found on the floor at the end of the night shift, the resident had a heart attack unrelated to the cares that may or may not have been provided overnight.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of medical records, facility records, facility polices, employee records and death records. Also, the investigator toured the facility and observed staff to staff, staff to resident and staff to visitor interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included mild cognitive impairment, arthritis, and morbid obesity. The resident's service plan included assistance with toileting, showering, dressing, medications. The assessment indicated the resident was able to walk without assistance.

The resident's care plan indicated the resident was to be woken up and brought to the bathroom at 1 a.m. by unlicensed caregivers on the night shift.

The facility's internal investigation indicated that one morning the unlicensed caregiver working the night shift heard the resident yelling for help at 5:30 a.m. The resident was found on the floor, 911 was called, and the resident transferred to the hospital.

The same document indicated the facility reviewed security footage of the night shift and the unlicensed caregiver sat in a chair throughout most of her shift and got up to document her nightly tasks at approximately 5:00 a.m.

The resident's notes indicated the resident passed away while enroute to the hospital.

The resident's death record reports the cause of death was cardiac arrest (a heart attack) and probable acute pulmonary embolism (a blood clot in the lung).

A task list from the same shift indicated the unlicensed caregiver documented bringing the resident to the bathroom at 1 a.m.

During an interview, a member of the facility management stated the documentation showed the unlicensed caregiver documented her cares to the resident at around 5 a.m. instead of documenting at the actual time when they were to be done. The management team member stated the facility cameras showed the unlicensed caregiving sitting in a chair and not moving until around 5 a.m.

During an interview, another member of the facility management team stated she viewed the video footage from that night but stated she was not able to tell who was actually sitting in the chair overnight.

The video footage was no longer available at the time of the investigation.

During an interview, a family member stated the resident had swollen ankles and lower legs the day before this incident which was unusual. The resident also reported that she was tired and not feeling well the day before the incident.

The attempts to interview the unlicensed caregiver working that shift were unsuccessful.

In conclusion, 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, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: NA.

Action taken by facility:
The facility terminated the unlicensed caregiver’s employment.

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
	32991	A. BUILDING: _____ B. WING _____	C 11/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(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 November 7, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL329912238C/#HL329916506M. No correction orders are issued.	0 000		