Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL334265122M
Compliance #: HL334261580C

Date Concluded: October 17, 2025

Name, Address, and County of Licensee Investigated:
Harmony View Assisted Living
1420 Second Street North
Sauk Rapids, MN 56379
Sterns County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, 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 they failed to provide health care when she developed a skin mass. As a result, the resident required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Hospital physicians determined lymphedema (swelling from excess fluid) caused the mass in the resident's groin. Prior to this hospitalization, the facility sent the resident to the hospital five times within two months due to her skin rashes, swelling, and groin pain. Subsequently, the resident discharged from the facility approximately one month prior to this hospitalization.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a case worker. The investigation included review of the resident records, hospital records, personnel files, staff schedules, and

related facility policy and procedures. Also, the investigator toured the facility observed staff performing wound care and medication administration.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes, morbid obesity, atrial fibrillation (abnormal heart rate), and fluid overload. The resident's service plan included assistance with medications, bathing, toileting, dressing, grooming, and transfers, behavior management, and wound care. The resident's nursing assessment indicated she appeared "unkept," and inadequately groomed, however she declined assistance from staff. The resident required staff to put Farrow Wraps (compression dressings) on her legs. The resident was forgetful, but able to communicate her needs.

Resident records indicated two months prior to discharge from the facility, she went to the hospital because she had pain in her left side (in her skin folds). Physicians determined the resident had a yeast infection and prescribed her topical medication.

Progress notes indicated two weeks later, the resident had abdominal pain and went to the emergency room (ER). Physicians prescribed an oral antibiotic medication and another topical medication for the skin rash. The hospital physician told the facility staff to have the resident's physician assistant (PA) complete a pelvic examination. (This did not occur, as the PA ordered a CT scan instead.)

Progress notes indicated another two weeks later, the resident was supposed to have a CT scan but refused to have the testing done once she was at the appointment. The resident went to the ER the next day due to hip pain but returned to the facility the same day.

Progress notes indicated two weeks later, the resident went to the ER and physicians determined she had cellulitis (skin infection) of her abdomen. The resident completed antibiotic medication and returned to the facility three days later. One day after she returned, a physician contacted the facility and told them to send her back to the hospital because her blood work results indicated she had an infection and required intravenous (IV) antibiotic medication. The facility sent her back to the hospital, then she returned to them three days later. The resident discharged from the facility five days later.

Medication administration records (MARs) indicated the facility gave the resident antibiotic medications her physician's prescribed after the various hospitalizations. The MARs also indicated the facility applied topical medications to her skin as the physicians prescribed.

The resident's PA went to the facility to evaluate her health status six times within two months prior to her discharge. PA notes indicated the resident could communicate her needs, but was not always agreeable with medical care and treatment.

Therapy records indicated a physical therapist (PT) went to the facility approximately two months before the resident discharged and treated her twice weekly to help her to gain

mobility and strength. Therapy notes indicated the PT provided education to the resident about managing lymphedema.

Hospital records indicated after the resident discharged from the facility to live at her new location, she went to the hospital four more times within one month due to falls and skin infections. She returned to the new location after each incident. But the resident fell again so she went back to the hospital, while she was there, physicians further addressed her skin concerns. The hospital records indicated the groin “mass” was lymphedema, and fatty tissue. This was approximately one month after she discharged from the facility to her new location.

During an interview, a manager said the resident made her own decision but was quite anxious. The manager said the resident frequently refused cares and treatments. The manager said the facility could not force the resident to have exams or treatments completed.

During an interview, a case worker said the resident discharged from the facility and went to live at a new location, but upon the resident’s arrival, their staff noticed the resident had a “basketball” sized mass in her groin, undetected by the facility before she discharged. The case manager said the facility staff members should have noticed this mass. The case manager said eventually the resident required hospitalization for the mass.

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. Unable, recent illness.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility coordinated medical appointments for the resident.

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
	33426	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONEY VIEW ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

(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 26, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL334261580C/#HL334265122M. No correction orders are issued.	0 000		