Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL215188524M
Compliance #: HL215185809C

Date Concluded: May 2, 2024

Name, Address, and County of Licensee Investigated:
Harmony Place Assisted Living
455 Main Avenue North
Harmony, MN 55939
Fillmore County

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

Evaluator's Name: Christine Bluhm, 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:
The facility neglected the resident when the facility did not complete the resident's assessment upon return from the hospital. The resident did not receive ordered suprapubic catheter site care or left heel wound care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While there was a delay in resuming cares with an outside homecare agency regarding the suprapubic care and left heel wound care, the facility took steps to reinstate those cares. The facility assessed the resident upon return, obtained orders for an outside home care agency to address the resident's wound care needs. During that time, the facility provided monitoring and basic care for the resident overseen by the family and the resident's physician and the wounds did not worsen.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case worker and the home care agency. The investigation included review of the resident record, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed other residents with similar treatment care plans.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and prostate cancer. The resident's service plan the resident required assistance with personal hygiene, incontinence care, catheter care and medication management. The resident's assessment indicated he had memory problems and was disoriented to place and time.

The resident's care plan indicated he had an established suprapubic catheter (a surgically created connection between the bladder and skin to drain urine due to obstruction of normal urinary flow) and a chronic left heel ulcer with ongoing treatment and monitoring.

The resident's clinic and hospital notes indicated the resident had episodes of abdominal cellulitis requiring wound care at the suprapubic site and courses of antibiotic therapy. The resident was hospitalized for cellulitis and urinary infection and underwent a suprapubic catheter exchange during the hospitalization.

Upon return to the facility, the resident's discharge hospital nursing report indicated the resident continued to have moisture and redness at the suprapubic site which needed to be cleaned per care plan and left open to air.

A review of the facility's assessment upon return from the hospital indicated the registered nurse did not identify any new concerns regarding the resident's suprapubic catheter or left heel ulcer.

Five days later, the progress notes indicated the catheter site had not been cleaned or cared for and had an infected appearance since returning from the hospital. The progress notes further indicated that doctors' orders were needed to continue wound care by the home care agency. The same document indicated the nurse cleaned the insertion site of the catheter, contacted the home care agency, scheduled a doctor's appointment, notified the family, and continued to monitor the resident.

During an interview, a corporate nurse stated she completed the resident's admission back to the facility and the resident was stable with no acute issues. She stated there were no wound care orders at that time of re-admission. She confirmed the facility did not provide wound care as part of their services and a home care agency was managing the wounds prior to hospitalization.

During interview, a facility nurse stated the wounds had been previously managed by an outside home care agency and new orders needed to be obtained by the provider for continuing the

wound care. The nurse stated that the resident did not go without monitoring and basic care of the site once the oversight was noticed. The nurse stated that an additional obstacle was that the provider ordered daily treatments, multiple times a day and local home care agencies could not accommodate. The nurse stated a plan was put into place where family assisted with cares in combination with a home care agency, but this took time to coordinate. She also confirmed the home care agency was necessary because complex wound care was not a service the facility provided.

During interview(s), multiple family members stated they were pleased with the care their father received from the facility and had no concerns about neglect.

The facility's current Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) indicated that their services did not include suprapubic catheter care or complex wound care and these services would need to be arranged with an outside home care agency.

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, the resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility collaborated with the resident's family, case manager and local home care agency to come up with a care plan to meet the resident's wound care needs.

Action taken by the Minnesota Department of Health:
No 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 04/09/2024

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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, the correction order is issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL215186462C/#HL215188865M and HL215188524M/HL215185809C On April 9, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 24 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL215186462C/#HL215188865M and HL215188524M/HL215185809C tag identification 0620.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.	0 620		

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0 620	Continued From page 2 (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to investigate unexplained injuries that included marks on the neck and upper body for one of one residents (R1) nor did the facility report the finding under the maltreatment of vulnerably adult act. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 620		

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0 620	Continued From page 3 R1's diagnoses included cellulitis and dementia.R1's service plan dated March 26, 2024 included R1 required assistance with all activities of daily living which included meals, housekeeping, laundry, safety checks, bathing, hygiene, incontinence care, mobility assistance and medication management. R1's assessment dated September 6, 2023, indicated R1 required full assistance with medication administration, grooming, bathing, dressing, and reminders for meals. R1 required an assist of two staff to turn and reposition in bed and an assist of one staff for transfers with a walker and gait belt, and staff assist for mobility. R1's decision making was severely impaired and had difficulty with communication and due to poor cognition, may not report abuse or neglect. R1's assessment indicated he had memory problems and disoriented to place and time. R1's progress notes dated September 25, 2023, at 2:39 p.m., indicated a verbal report from a resident assistant (RA) that worked on September 23, 2023, and noted R1 had a bruise of unknown origin under the right upper arm area with no on-call nurse or director notified by phone at time of discovery. Same note indicated R1's left side of neck inner skin fold was darker pink in color and may be warm moist from not having much air to the area. The same document indicated staff observed it two days prior in day it was edematous and looked very dark and concerning. There was a one-centimeter (cm) pale/almost white area in center of area that is not an open sore or needing treatment at this time. A hospice progress note dated September 25, 2023, a registered nurse (RN) noted a spongy	0 620		

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0 620	Continued From page 4 swollen bruised area to R1's left collarbone. The family member also described bruising to R1's under arm. The same note indicated hospice would see about getting padding for side rails. A hospice progress note dated September 27, 2023, indciated the RN noted the spongy area appeared more red/bruised than previous. A hospice prorgress note dated October 2, 2023 indicated R1 had a spongy area to the left collarbone was less spongy but purple bruising across whole chest. Provider here to discuss bruising, shoulder and chest X-ray ordered. On April 23, 2024, at 2:20 p.m., Manager-F was interviewed and stated she did not see any injuries on R1 first-hand because he had already transferred out of the facility. The family member had returned with photos of the neck and manager-F stated to her that it looked like someone could have choked him by the marks on his neck. Manager-F stated she did not do anything with the information. Email correspondence dated April 25, 2024, with the facilty indicated there was no further information to provide if a facility investigation or an injury assessment was completed after R1's redness or bruising was observed. The facility policy titled Vulnerable Adult Maltreatment - Prevention & Reporting, dated August 1, 2021, indicated staff who suspect maltreatment of a resident or has knowledge that a resident has sustained a physical injury which is not reasonably explained will take steps and contact the Minnesota Adult Abuse Reporting center no later than 24 hours after the maltreatment first suspected.	0 620		

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0 620	Continued From page 5 A review of the facilty's vulneable adult maltreatment reports indicated no report for this occurrence was filed. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 620		