*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL341505943M
**Compliance #:** HL341501142C

**Date Concluded:** August 3, 2023

**Name, Address, and County of Licensee Investigated:**

Harrison Bay Senior Living
1861 Commerce Blvd
Mound, MN 55364
Hennepin County

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

**Evaluator's Name:** Lena Gangestad, RN
Special Investigator

Finding: **Not Substantiated**

**Nature of the 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 failed to order the resident's pain medications and did not properly maintain her nerve stimulator for pain relief. Additionally, the facility failed to check on the resident at night which led to yeast infections.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was not substantiated. While there was an occasion when a medication ran out, this was due to difficulty with insurance coverage and the facility worked to resolve this issue. There was an occasion when the resident's nerve stimulator was not properly charged, and the facility put new interventions in place to prevent recurrence of this issue. While the resident did develop a yeast infection, the resident received treatment for this and the facility provided nighttime cares for incontinence.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted the resident's family member. The investigation

included review of resident's records. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living unit. The resident’s diagnoses include osteoarthritis and weakness. The resident’s service plan included assistance with all activities of daily living which included toileting and incontinence cares assist three times a day and medication administration. The resident’s assessment indicated she was one person assist with transfers. Based on the progress notes, the nerve stimulator was charged twice a week by nursing.

According to the medication administration record (MAR), the resident missed one dose of her clotrimazole, but the facility restocked it the next day. A few months later, the resident ran out of Lidocaine patches, and the family had to provide them because insurance did not cover for it. However, the resident did not miss any lidocaine treatments as it was ordered to be applied 12 hours on and 12 hours off.  The medication administration records indicated the resident received a prescription to receive treatment for a yeast infection for approximately six months. The MAR indicated the resident’s pain medication regimen was adjusted over several months. The order for oxycodone ½ five milligram (mg) tablet every four hours as needed was changed to twice daily scheduled and twice daily as needed. A review of the MAR did not identify an occasion in which the scheduled medication was not given multiple times in a row.

During an interview, family member #1 stated staff members were responsive to the resident's needs, assisting her to the bathroom whenever she called, and changing her pad around 3 and 5 in the morning. The resident also had the opportunity to enjoy a jacuzzi bath downstairs once a week, and even twice a week if desired. The family member confirmed the staff administered pain medication to the resident as prescribed, every four hours apart. However, he mentioned having short-term memory loss and could not recall if the staff ever forgot to charge the resident's nerve stimulator. Overall, he expressed satisfaction with the care provided.

In another interview, family member #2 stated everything had improved. The resident had a history of a broken back and in continuous pain. In the past, there was an incident where the facility ran out of oxycodone, leaving the resident without pain medication for several days. However, family member #2 stated could not recall when this occurred.  Additionally, the family member mentioned the staff was supposed to change the resident at night, but they did not do it, resulting in a painful rash.

During an interview, the unlicensed staff member explained the care tasks performed for the resident, including toileting care, changing briefs, clothes, and providing perineal care as needed. She confirmed regular checks on the resident due to her medication schedule, with brief changes occurring every 2 hours or as needed. She stated she knew of the resident’s nerve stimulator, but the nurses made sure it was charged.

In an interview, a member of the management team acknowledged the incident with the Lidocaine patch, attributing it to insurance not covering the medication so the family was informed and got a supply.  He did not recall an incident involving a shortage of oxycodone but confirmed the nurses monitored and charged the nerve stimulator twice a week. He stated the caregivers checked on the resident three times during a night for incontinence.

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, attempt was unsuccessful.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: Not Applicable

**Action taken by facility:**
The facility is collaborating with the family to address any concerns they had. In response to the incidents happened in the past, the facility staff have updated the resident's care plan to include regular charging of the nerve stimulator twice a week, and the resident will also be checked three times during the night to ensure she remains dry and comfortable.

**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 |
|---|---|---|---|
| | 34150 | A. BUILDING: _____ B. WING _____ | C 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HARRISON BAY SENIOR LIVING | 1861 COMMERCE BOULEVARD MOUND, MN 55364 |

| (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<br><br>On July 19, 2023, the Minnesota Department of Health initiated an investigation of complaints #HL341505943M/HL341501142C. No correction orders are issued. | 0 000 | | |