Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL348229383M
Compliance #: HL348228309C

Date Concluded: May 16, 2025

Name, Address, and County of Licensee Investigated:
Harding Place
2448 296th Avenue
Pierz, Minnesota 56364
Morrison County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 have a system in place to ensure availability of medication refills and staff failed to administer medications as prescribed. The resident missed several doses of medication and was evaluated in the emergency room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident missed four days of a medication used to assist with urination. The facility failed to update the resident's provider. The resident had difficulty using a catheter to empty his bladder and experienced significant pain. The resident was sent to the emergency room at his request and was found to have a full bladder. The resident was treated in the emergency room and discharged back to the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case manager and primary care provider. The investigation included review of the resident records, hospital records, schedules, and related facility policy and procedures. Also, the investigator observed medication storage at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included panhypopituitarism (the lack of hormones from the pituitary gland), heart failure, and neurogenic bladder. The resident's service plan included assistance with medication administration. resident's assessment indicated the resident was independent with activities of daily living and could use a straight catheter on himself to empty his bladder. The facility managed the resident's medications.

The resident's record indicated he missed four days of Tamsulosin, a medication to that assists with urination. The record lacked evidence the resident's primary care provider (PCP) had been updated of the missed doses. The facility failed to complete medication error reports for the missed doses. Documentation indicated the resident had complaints of pain in the lower abdomen and couldn't sleep as it hurt to move. The resident rated the pain as a six out of ten. The resident reported to staff he hadn't received one of his medications for three days. The resident stated he was also out of his normal straight catheter supplies and staff found some supplies in the facility that were not in his size. The resident was not able to get any urine output. The on-call nurse was notified and advised staff to give him another hour to try catheter himself and to call back if he wasn't able to empty his bladder or had increased pain. Staff called back an hour later to report the resident had some pink tinted urine output and pain had improved. Almost two hours later, the resident requested an ambulance be called due to increased pain.

Hospital records indicated the resident was seen in the emergency room for complaints of lower abdominal pain, difficulty catheterizing himself, and decreased urine output. The resident reported he had run out of his Tamsulosin three days prior and the pain started about two days ago. The resident stated the pain was so bad, he had trouble sleeping. The resident stated he had a lot of discomfort trying to cath himself and he could get only 50 cc of urine out. Emergency room staff used a bladder scanner and determined he had at least 600 cc of urine still in his bladder (maximum bladder capacity is around 700 to 800 milliliters.) Emergency room staff prescribed new medications to the resident, however he was reported to have said "he has difficulties receiving prescriptions given that it is the weekend, and he likely will not be able to have prescriptions filled until Monday..."

Seven months of the resident's medication administration record (MAR) were reviewed, and each month, the resident missed doses of essential medications due to not being in stock. The record lacked evidence the primary care provider was updated of any of these instances of missed medications. In total, 58 doses of medication were not able to be administered.

During an interview, a licensed practical nurse (LPN) stated she started helping out at the facility shortly before the resident was sent to the emergency room. The LPN stated there had been ongoing registered nurse (RN) turnover, so she began working a few hours a week to help out. The LPN stated the primary care provider should have been updated on the missed doses and was not sure why they were not notified. The LPN stated they had issues with the pharmacy the resident was using so they had switched to a different pharmacy however issues of getting refills continued. The LPN stated sometimes the medications would run out before insurance would authorize a refill or they'd have to wait for the provider to authorize a refill.

During an interview, the RN stated she wasn't initially aware of the incident that resulted in an emergency room visit and stated it should have been followed up on. The RN stated they had ongoing issues with the pharmacy, so they switched to a different pharmacy. The RN stated there had been nurse turnover and she helped out at the facility when there isn't a permanent nurse. The RN stated it would depend on why a medication wasn't given if it would be a medication error or reportable to the provider and if it was a pharmacy issue they'd follow up with the pharmacy.

During an interview, a representative with the primary care provider's office confirmed they did not receive any notifications on missed medication doses over the seven-month period of time.

During an interview, the resident's family member stated she had not been notified of the missed doses of medications and would expect the facility would communicate any issues with obtaining medications.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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:
No action taken.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Morrison County Attorney
Pierz City Attorney
Pierz Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34822	A. BUILDING: _____ B. WING _____	C 04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARDING PLACE	24448 296TH AVENUE PIERZ, MN 56364

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are 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: #HL348229383M/ #HL348228309C On April 14, 2025, 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 17 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL348229383M/ #HL348228309C, tag identification 0620, 1760, 2360.	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 immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one residents (R1) reviewed for maltreatment. 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: The licensee failed to immediately report	0 620		

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0 620	Continued From page 3 suspected neglect after the resident missed several days of of a medication that relaxes the muscles of the prostate and bladder. The resident was sent to the emergency room and treated for urinary retention. Facility staff failed to notify the resident's primary care provider, failed to notify the resident's family, and failed to investigate the incident. On April 16, 2025, at 12:45 p.m., registered nurse (RN)-A was asked if the incident should have been reported and she stated it would depend on the situation. RN-A stated she just learned about the situation within the last week. The licensee's Report of Maltreatment of a Vulnerable Adult dated August 1, 2021, indicated the facility would report suspected maltreatment of a resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet	01760		

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01760	Continued From page 4 the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure medications were readily available to administer as ordered for one of one residents (R1). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: R1's diagnoses included panhypopituitarism (the lack of hormones from the pituitary gland), heart failure, and neurogenic bladder. R1's service plan dated August 1, 2024, indicated the resident received assistance with medication administration. R1's assessment dated November 4, 2024, indicated the resident was independent with activities of daily living and could use a straight catheter on himself to empty his bladder. The facility managed the resident's medications. R1's record contained an order for Tamsulosin 0.4 milligrams (mg), take two capsules at bedtime. The medication was used to improve	01760		

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01760	Continued From page 5 urination for people with benign prostatic hyperplasia, an enlarged prostate. OCTOBER R1's October 2024 medication administration record (MAR) indicated the resident's Tamsulosin 0.4 mg capsule was not available on October 13, October 29, October 30, October 31. R1's record lacked evidence the resident's primary care provider (PCP) was notified the medication was out and that several doses had been missed. R1's record lacked evidence medication error reports were completed for the missed doses. NOVEMBER R1's November 2024 MAR indicated the resident's Tamsulosin 0.4 mg capsule was not available on November 1 and November 6. R1's record lacked evidence the resident's primary care provider (PCP) was notified the medication was out and that several doses had been missed. R1's record lacked evidence medication error reports were completed for the missed doses. Progress notes indicated on November 1, the resident had complaints of pain in the lower abdomen and couldn't sleep as it hurt to move. The resident rated the pain as a six out of ten. The resident reported he hadn't received one of his medications for three days. he resident stated he was also out of his normal straight catheter and staff found some supplies in the facility that were not in his size. The resident was not able to get any urine output. The on-call nurse was	01760		

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01760	Continued From page 6 notified and she advised staff to give him another hour to try catheter himself and to call back if he wasn't able to empty his bladder or had increases in pain. Staff called back an hour later to report the resident had some pink tinted urine output and pain had improved. Almost two hours later, the resident requested an ambulance be called due to increased pain. Hospital records indicated the resident was seen in the emergency room on November 2, 2024, for complaints of lower abdominal pain, difficulty catheterizing himself, and decreased urine output. The resident reported he had run out of his Tamsulosin three days prior and the pain started about two days ago. The resident stated the pain was so bad, he had trouble sleeping. The resident stated he had a lot of discomfort trying to cath himself and he could get only 50 cc of urine out. Emergency room staff used a bladder scanner and determined he had at least 600 cc of urine still in his bladder. (Maximum bladder capacity is around 700 to 800 milliliters.) Emergency room staff prescribed new medications to the resident, however he was reported to have said "he has difficulties receiving prescriptions given that it is the weekend and he likely will not be able to have prescriptions filled until Monday..." R1's record contained an order for Desmopressin 0.001% spray twice daily. The medication was used to treat diabetes insipidus. It is similar to a hormone produced by the body to reduce the flow of urine. R1's November 2024 MAR indicated the resident's Desmopressin 0.001% spray was not available for the morning dose on November 16, November 17, November 18.	01760		

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01760	Continued From page 7 R1's November 2024 MAR indicated the resident's Desmopressin 0.001% spray was not available for the evening dose on November 15, November 16, November 17. R1's record lacked evidence the resident's PCP was notified the medication was out and that several doses had been missed. R1's record lacked evidence medication error reports were completed for the missed doses. On November 15, 2024, staff documented the resident was very upset during meds that night as his nasal spray was empty and there was no replacement. The resident stated that if there continued to be an issue with medications he was going to move somewhere else. Progress notes indicated staff called the on-call nurse on November 16, 2024, to report the resident was out of Desmopressin. The on-call nurse advised staff to chart the medication as not administered and to leave a note for the facility nurse so that medication can be ordered as soon as possible. Staff documented in a separate note that she had called the on-call nurse and the nurse "stated he should be fine until Monday when it can be gotten by nurse." DECEMBER R1's December 2024 MAR indicated the resident's Tamsulosin 0.4 mg capsule was not available on December 5, December 6, December 7, and December 8. R1's record lacked evidence the resident's PCP was notified the medication was out and that	01760		

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01760	Continued From page 8 several doses had been missed. R1's record lacked evidence medication error reports were completed for the missed doses. Progress notes indicated staff called the on-call nurse on December 6, 2024, as the resident didn't have any Tamsulosin and "according to staff, the resident was concerned that the last time they missed this medication, they became hospitalized." The on call nurse advised staff to chart that the medication was unavailable and to call nursing the next day to call the pharmacy. On December 9, 2024, the resident was sent to the emergency room due to a sudden onset of shortness of breath and chest pain. The resident was diagnosed with dehydration. JANUARY A note in the resident's record indicated the resident switched to a new pharmacy on January 6, 2025. R1's record contained an order for Cortef 5 mg, take three tablets in the morning and two tablets at night. The medication was a steroid to treat autoimmune disorders. R1's January 2025 MAR indicated the resident's Cortef 5 mg tablet was not available for the morning dose on January 7, January 8, January 9, January 10, January 11, January 12, January 13. A note from the nurse entered on January 8 indicated there was a miscommunication with pharmacy and the medication was to be delivered that evening. R1's January 2025 MAR indicated the resident's Cortef 5 mg tablet was not available for the evening dose on January 5, January 6, January 7,	01760		

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01760	Continued From page 9 January 8, January 9, January 10, January 11, January 12. R1's record contained an order for Hydralazine 10 mg tablet, one tablet three times per day. The medication was used to treat high blood pressure. R1's January 2025 MAR indicated the resident's Hydralazine 10 mg tablet was not available for the afternoon dose on January 29 and January 30. R1's January 2025 MAR indicated the resident's Desmopressin 0.001% spray was not available for the morning dose on January 16, January 17, January 18, January 19. R1's January 2025 MAR indicated the resident's Desmopressin 0.001% spray was not available for the evening dose on January 15, January 16, January 18, January 19. The January 17 dose was marked as administered, despite not being in stock. R1's record lacked evidence the resident's PCP was notified the medication was out and that several doses had been missed. R1's record lacked evidence medication error reports were completed for the missed doses. Progress notes indicated on January 15, 2025, the resident voiced several concerns to staff, including that his medications were always missing. Earlier in the evening, staff documented the resident's nasal spray was out and the resident became very upset saying "he is sick of this fucking bull shit and that he wants to move." On January 13, 2025, the resident reported to staff that he "hasn't had his steroid pill since 1/5/25 and he is becoming concerned about the effects he is having because of this. Resident	01760		

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01760	Continued From page 10 stated that he feels 'tired, weak, less talkative and crabby'..." FEBRUARY R1's February 2025 MAR indicated the resident's Desmopressin 0.001% spray was not available for the morning and evening dose on February 4, February 5. R1's record lacked evidence the resident's PCP was notified the medication was out and that several doses had been missed. R1's record lacked evidence medication error reports were completed for the missed doses. Progress notes indicated on February 4, a facility nurse called the pharmacy to follow up on the refill of the nasal spray. MARCH R1's March 2025 MAR indicated the resident's Desmopressin 0.001% spray was not available for the evening dose on March 27. The resident's Tamsulosin was also marked as not given. Progress notes indicated staff called the on-call nurse on March 27 to report the medications were not available. The on-call nurse attempted to call the pharmacy but it was closed. A communication note was sent to the facility nurse. R1's March 2025 MAR indicated the resident's March 28 medications including Aspirin 81 mg, iron supplement, Hydralazine 10 mg tablet, Hydrocortisone 5 mg tablet, Isososobide Mononit ER 30 mg (a medication to widen blood vessels, making it easier for blood to flow through), Levotyhroxine 150 microgram tablet (a hormone	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34822	A. BUILDING: _____ B. WING _____	C 04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARDING PLACE	24448 296TH AVENUE PIERZ, MN 56364

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01760	Continued From page 11 to treat an underactive thyroid), Metoprolol ER 100 mg tablet, and vitamin C were not given as the medications were not available. R1's record lacked evidence the resident's PCP was notified the medication was out and that several doses had been missed. R1's record lacked evidence medication error reports were completed for the missed doses. APRIL R1's April 2025 MAR indicated the resident's Desmopressin 0.001% spray was not available for the morning dose on April 12, April 13, April 14. R1's April 2025 MAR indicated the resident's Desmopressin 0.001% spray was not available for the evening dose on April 12, April 13. R1's record lacked evidence the resident's PCP was notified the medication was out and that several doses had been missed. R1's record lacked evidence medication error reports were completed for the missed doses. On April 14, 2025, at 12:00 p.m., licensed practical nurse (LPN)-B stated she had started helping out at the facility shortly before the resident was sent to the emergency room. LPN-B stated there had been ongoing registered nurse (RN) turnover so she began working a few hours a week to help out. LPN-B stated the PCP should have been updated on the missed doses and was not sure why they were not notified. LPN-B stated they had issues with the pharmacy the resident was using so they had switched to a different pharmacy however issues of getting refills continued. LPN-B stated sometimes the	01760		

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01760	Continued From page 12 medications would run out before insurance would authorize a refill or they'd have to wait for the provider to authorize a refill. On April 16, 2025, at 12:45 p.m., registered nurse (RN)-A stated she wasn't initially aware of the incident in November and stated it should have been followed up on. RN-A stated they had ongoing issues with the pharmacy so they switched to a different pharmacy. RN-A stated there had been nurse turnover and she will help out at the facility when there isn't a permanent nurse. RN-A stated it would depend on why a medication wasn't given if it would be a medication error or reportable to the provider and if it was a pharmacy issue they'd follow up with the pharmacy. On April 17, 2025, at 11:24 a.m., RN-A wrote, "I reviewed documentation further in Rtasks [electronic medical record]. Per Rtasks reports, the medication had been verified/checked in by nursing staff during that time frame as being present in the building. The staff members identified as responsible for the omission have received medication errors and will be receiving follow-up education." RN-A later clarified the dates reviewed for the Tamsulosin were October 13, October 29, October 30, October 31, November 1, November 6, December 5, December 6, December 7, December 8. The licensee's Medication & Supplies Reordering policy dated August 1, 2021, indicated the facility would reorder medications or supplies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	