Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL368623627M
Compliance #: HL368624625C

Date Concluded: July 17, 2023

Name, Address, and County of Licensee Investigated:

Harmony Homes LLC
7006 Morgan Ave N
Brooklyn Center, MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Maerin Renee, 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):
It is alleged the facility neglected the resident when staff did not administer the resident's thyroid medication (methimazole) as prescribed. The resident developed respiratory distress and required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The resident did not receive his daily dose of methimazole (a medication used to treat hyperthyroidism by decreasing the amount of thyroid hormone circulating in the body) for 15 days. The resident developed respiratory distress and was hospitalized. The resident was diagnosed with thyroid storm, (a life-threatening health condition associated with undertreated hyperthyroidism, a condition where the thyroid gland makes and releases high levels of thyroid hormone). The resident passed away in the hospital. The cause of death was thyroid storm.

The investigator conducted interviews with facility staff members, including administrative, nursing, and unlicensed staff. The investigation included review of the resident's medical record, hospital records, facility policies and procedures, and personnel files. In addition, the investigator observed staff administering medications and interacting with residents.

The resident resided in an assisted living facility with diagnoses including chronic obstructive pulmonary disease and Graves' disease (hyperthyroidism). The resident's service plan indicated the resident received assistance with activities of daily living, tube feedings, housekeeping, laundry, and medication management. The resident's assessment indicated the resident had trouble swallowing with recurrent lung aspirations, requiring help with tube feedings.

Review of the resident's medication administration record (MAR) indicated the resident was prescribed one tablet of methimazole 10 milligrams (mg) daily. The resident's MAR indicated staff did not administer methimazole as prescribed to the resident for 15 days and documented the medication was not available. The medication was transcribed onto the MAR as "Methimazole (Hold)," and dates for the month were blackened out. Two staff members initialed two dates on the MAR, indicating methimazole was not available, and all other dates were left blank. Methimazole was absent from the MAR the following month, although there was no prescriber order to discontinue that medication.

The residents progress notes indicated five days after admission to the facility, the resident had no concerns, and an appointment to establish care at a primary care clinic had been made. Twelve days after admission, a progress note indicated the resident's appointment was rescheduled for later that week. The next day, the resident reported difficulty breathing. The progress notes indicated the resident continued to complain of difficulty breathing for the next two days until the resident was admitted to the hospital for difficulty breathing and weakness.

Although the resident had not received Methimazole, the residents progress notes contained no documentation the resident's physician was notified the resident was not receiving methimazole as prescribed.

When interviewed, a facility administrator stated the resident did not have some of his medications when he was admitted to the facility. The administrator stated the facility called the resident's care coordinator at his primary care clinic and received no response, so an appointment was made at a different clinic to establish care and get medication refills. The facility staff were late bringing the resident to the appointment, so staff rescheduled the appointment for later that week. The administrator stated the facility made no further attempts to get the methimazole refilled. The resident became short of breath on the day of his rescheduled appointment, so the facility sent him to the hospital.

When interviewed, a nurse stated when the resident was admitted, he was out of some medication. The nurse contacted the resident's previous facility requesting refills until the residents appointment at the primary care clinic, but they would not. The nurse made no other

attempts to refill the resident's medications other than making an appointment at the primary care clinic.

During an interview, a physician stated the development of thyroid storm and respiratory distress could possibly be attributed to the resident not receiving the methimazole.

When interviewed, the resident's family stated the resident missing his methimazole for 15 days contributed to the thyroid storm, which resulted in the resident's death.

The resident died 27 days after being hospitalized. The resident's death certificate indicated the resident's immediate cause of death was thyroid storm.

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: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
None.

Action taken by the Minnesota Department of Health:

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
Hennepin County Attorney
Brooklyn Center Attorney
Brooklyn Center Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36862	A. BUILDING: _____ B. WING _____	C 05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOMES LLC	7006 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430

(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, 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: #HL368624625C/#HL368623627M On May 31, 2023, 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 2 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL368624625C/#HL368623627M, tag identification 2310 and 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 th 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.	
02310 SS=J	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36862	A. BUILDING: _____ B. WING _____	C 05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOMES LLC	7006 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
02310	Continued From page 1 resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure care and services were provided according to a suitable and up-to-date plan and subject to accepted health care and medical standards for one of one residents (R1) who received medication management services with records reviewed. The facility failed to ensure a prescribed medication was administered as ordered, and R1 suffered a myocardial infarction caused by the condition ("thyroid storm") the medication was intended to address, and subsequently died from that condition. This practice resulted in a level four violation (a violation that results in 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 was admitted to the facility on August 18, 2022. R1's diagnoses included chronic obstructive pulmonary disease, traumatic brain injury, and Graves disease. R1's service plan, dated August 18, 2022, indicated R1 received assistance with activities of daily living, tube feedings, housekeeping, laundry, and medication management. Review of R1's medication administration record	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36862	A. BUILDING: _____ B. WING _____	C 05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOMES LLC	7006 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
02310	Continued From page 2 (MAR) for August 2022, indicated R1 was prescribed one tablet of methimazole (a medication used to decrease the amount of thyroid hormone) 10 milligrams (mg) daily. Review of R1's profile indicated he was taking the methimazole to treat thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm-Graves' disease (hyperthyroidism). R1's MAR indicated staff did not administer methimazole as prescribed to the resident for fifteen days, from August 19, 2022-September 2, 2022, and documented the medication was not available. The medication was transcribed onto the MAR as "Methimazole (Hold)," and dates for the month of August were blackened out. Two staff members initialed two dates on the MAR, August 20 and August 21, indicating methimazole was not available. All other dates on the MAR were left blank. Methimazole was not transcribed onto the MAR for September 2022, although there was no prescriber order to discontinue that medication. A review of progress notes indicated on August 23, 2022, R1 verbalized no concerns, and an appointment to establish care at a new primary care clinic had been made. On August 30, 2022, it was documented that R1's appointment was rescheduled for September 2, 2022. A progress note dated August 31, 2022 indicated R1 reported difficulty breathing. R1 continued to complain of difficulty breathing for the next two days. On the morning of September 2, 2022, after missing his daily dose of methimazole for fifteen days, R1 experienced a respiratory emergency and was sent to the hospital. There was no indication in the progress notes that specific attempts were made to obtain a refill for methimazole nor was the physician notified the resident was not	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36862	A. BUILDING: _____ B. WING _____	C 05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOMES LLC	7006 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
02310	Continued From page 3 receiving methimazole as prescribed. Hospital records dated September 2, 2022, indicated upon admission, R1 was diagnosed with thyroid storm, hyperthyroidism, Graves' disease, and non-ST-elevation myocardial infarction due to thyroid storm. Laboratory results indicated R1's thyroid stimulating hormone (TSH) was undetectable and his free T-4 (fT4) was over the upper limit of the test. R1's condition worsened over the course of the hospitalization, and he was pronounced dead on September 28, 2022. R1's death certificate indicated R1's immediate cause of death was thyroid storm. When interviewed, the licensed assisted living director (LALD)-A stated R1 was admitted to the facility without any methimazole. After calling R1's care coordinator at the Minneapolis VA Medical Center (R1's primary care clinic) and receiving no response, staff chose to make an appointment at a different clinic to establish care. The facility made no further attempts to contact the Minneapolis VA Medical Center for a methimazole refill. The appointment at the new clinic was scheduled for August 29, 2022. On the day of the appointment, staff and R1 were late to arrive, so the clinic would not see R1 that day. The clinic rescheduled the appointment for September 2, 2022. LALD-A said, outside of making two clinic appointments, there were no further attempts to get R1's methimazole refilled. During an interview, registered nurse (RN)-B stated R1 was getting low on some of his medications when he was admitted. RN-B asked R1's previous facility if they would provide refills until his appointment at the primary care clinic.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36862	A. BUILDING: _____ B. WING _____	C 05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOMES LLC	7006 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
02310	Continued From page 4 The previous facility told the nurse they were unable to provide refills, as the resident no longer lived there. The nurse made no other attempts to refill the resident's medications. . The facility policy titled Medication Supply, dated August 1, 2021, indicated the facility would work with the resident/resident representative, prescriber, pharmacy, and insurance company to provide the resident with the appropriate supply of medications as prescribed. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	02310		
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 resident 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		