Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL205722784M
Compliance #: HL205724606C

Date Concluded: December 7, 2022

Name, Address, and County of Licensee Investigated:
Harmony House of Motley
900 Eastwood Lane South
Motley, MN 56466
Morrison County

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

Evaluator's Name: Jill Hagen, RN, Special Investigator

Finding: Inconclusive

Nature of Visit:
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 alleged perpetrator (AP), facility staff, abused a resident when the AP caused bruising to the resident's left ear and right forearm.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Although the AP worked the day the resident's bruises were discovered, there were no witnesses to the AP abusing the resident. The resident could not remember the cause of the bruising until after three staff interviews when the resident provided a generalized description of the AP.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident's medical record, the AP's personnel file, staff schedules, and facility policies and procedures. Also, the investigator observed the facility, resident rooms, and common areas.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's dementia, heart disease with long term anticoagulant (blood thinner) medication use. The resident's service plan included staff assistance with dressing, grooming, bathing, toileting, eating, medication administration, incontinence care, and transfers. The resident ambulated independently or with stand by assistance. The resident made basic needs known to staff but required assistance with all decision making. The resident was at risk to be abused by others.

A progress note indicated staff observed a bruise on the top of the resident's left ear. The resident had no complaints of pain and no memory of hitting his ear. The resident was out of the facility earlier in the day with family. About three hours later, staff observed bruising on the resident's right forearm.

A progress note documented the following day indicated the resident told a staff person a man with brown hair, black skin, and medium height twisted his right arm and pulled his left ear. Later when asked by staff, the resident stated the "guy that works here pulled" his ear.

During an interview, the unlicensed staff who worked with the AP the day the bruising was observed stated she had no concerns with the care provided to the resident by the AP. The staff did not observe the AP abuse the resident, and initially when the resident was asked they could not remember what caused the bruising.

During an interview, the nurse stated staff called her to the facility to observe the resident's bruises on the left ear and right forearm. The resident had no complaints of pain and could not remember the cause of the bruising.

During an interview, management stated when other staff interviewed the resident he had no memory of the cause of the bruising. However, when she interviewed the resident the following day, the resident stated a short man with brown skin and brown hair twisted his right arm and pinched his left ear. Management stated when interviewed, the AP provided no additional information.

During interviews with multiple staff, they had no concerns with the care provided to residents by the AP.

The AP failed to respond to a subpoena.

When contacted, law enforcement had no investigation into the incident.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451. A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Vulnerable Adult interviewed: Refused.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Did not respond to attempts to contact.

Action taken by facility:
The AP was no longer was employed by the facility.

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
	20572	A. BUILDING: _____ B. WING _____	C 11/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE OF MOTLEY I	900 EASTWOOD LANE SOUTH MOTLEY, MN 56466

(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 Initial comments On November 8, 2022, the Minnesota Department of Health initiated an investigation of complaint HL205724606C/HL205722784M and HL205724678C/HL205722802M. No correction orders are issued.	0 000		