Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL215187962M
Compliance #: HL215183961C

Date Concluded: January 30, 2025

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: Willette Shafer, 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(s):
The alleged perpetrator (AP) financially exploited the resident when the AP accepted forty dollars from the resident to buy him alcohol, never purchased anything for the resident, and kept the money.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was not substantiated. The resident provided conflicting statements regarding the allegation in the law enforcement report and investigator interview. The law enforcement report indicated the initial account of theft by the resident indicated the AP took the money to buy him wine, however another resident at the facility reported witnessing the resident go to the store himself. The AP denied he accepted money from the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record,

facility internal investigation, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator toured the facility and observed resident and staff interactions.

The resident resided in an assisted living facility. The resident's diagnoses included anxiety, depression, type two diabetes with loss of left leg below knee. The resident's service plan included assistance with medication administration, meals, bathing reminders, safety checks, and housekeeping.

According to the resident's progress notes, the resident made false accusations against the AP in the past. One progress note indicated the resident reported the AP said "go fuck yourself" when the resident gave his tray to the AP. When investigated by management, the caregiver assigned to the resident said she removed the resident's tray from his room and the AP had no contact with the resident. Another progress note indicated the resident sat at the table in the dining room directly across from the kitchen window and the resident was observed by other staff members glaring at the AP and smirking.

A law enforcement report indicated the resident gave the AP forty dollars to buy him wine. The AP denied receiving money from the resident. Other staff members thought the resident tried to falsely report the AP after the AP asked the resident to leave the kitchen area. Another resident reported the resident drove himself to the liquor store the night before and bought himself alcohol. The resident smelled of alcohol at the time of the police report.

The AP's training record indicated the AP received vulnerable adult maltreatment training upon hire and annually.

During an interview, a member of management said the resident reported the incident after he became angry at the AP for not allowing the resident in the kitchen. She said an internal investigation was conducted and there was no way to prove the AP took money from the resident. The AP continued to work at the facility.

During an interview, the resident said he never gave the AP money to buy him alcohol. He said he gave the AP his bank card to remove money from the automated teller machine (ATM) for him. When the AP took money out for the ATM for the resident, he used $43 dollars to put gas in his vehicle. The AP never repaid the resident. The resident denied any other incidents.

During an interview, the AP said he never accepted money from the resident to buy him alcohol. He also denied the resident gave him his bank card to take money out of the ATM. The AP said he believed the resident retaliated against him after the resident was asked to leave the kitchen area.

During an interview, the nurse said the incident happened before she worked at the facility. She said the resident later denied giving the AP $40 to buy him alcohol and instead changed his

allegation and reported the AP stole $160 from him. The resident was unable to provide more details about the incident, like if he gave the AP cash or if he gave the AP his bank card to take money out of the ATM. She said the resident changed his story several times and all allegations were reported to the police.

In conclusion, the Minnesota Department of Health determined financial exploitation 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.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Not Applicable.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation and law enforcement was notified. The incident happened under a previous owner.

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
	21518	A. BUILDING: _____ B. WING _____	C 01/02/2025

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, 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: HL215183961C/HL215187962M HL215189261C/HL215186261M On January 2, 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 29 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL215189261C/HL215186261M, tag identification 2360. No correction orders are issued for complaint HL215183961C/HL215187962M.	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person 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.	