Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL215186261M
Compliance #: HL215189261C

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: Substantiated, individual 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 alleged perpetrator (AP) abused the resident when the AP engaged in a sexual relationship with the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP, while employed at the facility, engaged in a sexual relationship with the resident while he lived at the facility and received services. Both parties admitted to having a sexual relationship that lasted for months.

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, 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, and 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.

The facility underwent a change in ownership after the relationship between the AP and the resident had ended. The current owners supplied all investigative records available from the previous ownership. The prior owners, inappropriately, allowed the relationship between the AP and resident and added the relationship to the resident's care plan.

The resident's previous care plan implemented by the previous owners indicated "resident was in a consented relationship with a staff member." The care plan indicated the facility had done an investigation and found no evidence of abuse, sexual or financial exploitation.

The resident's service notes indicated the resident was out of the facility for several overnight passes during his relationship with the AP. The service record indicated the resident was on a leave of absence "with a friend."

After the change in ownership, a grievance record indicated the resident expressed sadness over the ending of a recent relationship. Progress notes indicated the resident expressed anxiety keeping him in bed due to worry about his romantic relationship and lack of explanation of it ending.

Per the resident's progress notes, a staff member reported concerns about a relationship between the resident and AP. She reported the AP told her they were in love and planned to move in together. A few days later their relationship ended. The AP blamed the resident for being transferred to memory care and not being able to work on the assisted living side. A prior member of management, who was also a nurse, documented the relationship between the AP and the resident in the resident's care plan.

Service records indicated in the weeks following the ending of the relationship between the AP and the resident, he had an increase in using anti-anxiety medication.

The AP's training filed indicated the AP received maltreatment of vulnerable adults training before she engaged in a sexual relationship with the resident.

During an interview, the resident said he met the AP while he lived at the facility and the AP worked at the facility. He said the relationship started as a friendship and developed into a sexual relationship a few months later. He said the sexual relationship lasted a few months and then the AP broke up with him. The resident said he notified the police after the AP's husband called and threatened him. The resident said he gave the AP money for rent and food. When

the facility changed ownership, the new owners told the resident the relationship was inappropriate.

A police report indicated a relationship between the resident and AP ended and the AP and the AP's husband were sending threatening and harassing text messages to the resident. The AP believed she was terminated because of the resident.

During an interview, a member of the previous management-1, who was also a nurse, said she was made aware the AP and resident were in a relationship. She reported the relationship to corporate and another member of management, but she was unable to provide names of who she reported the relationship to. She thought the relationship was inappropriate as the resident resided at the facility and received services, but both the resident and the AP gave consent. She was unaware if the facility filed a vulnerable adult report at the time the incident was discovered. She said she added the relationship to the resident's care plan as they both consented to their sexual relationship.

During an interview, another member of the previous management-2 said several staff members reported the AP was spending long periods of time in the resident's room at night. While the AP was on medical leave the resident requested a three-day pass to go camping with friends. While the resident was on pass, a facility staff member observed the resident's vehicle at the AP's house. When the AP and resident were confronted, they admitted to being in a relationship and wrote statements consenting to their relationship. When corporate was informed of the relationship, corporate directed facility management to add the relationship to the resident's care plan and schedule to AP to work in memory care. However, at times the AP still worked on the assisted living unit. The member of management-2 said she received no training when given the management position and was unaware if a vulnerable adult report should have been filed.

During an interview, a member of the current management team said when she was hired, the relationship between the AP and resident was documented in the resident's care plan and the AP still worked at the facility. When the new ownership was effective less than one month later, the AP was not rehired. She said this was an inappropriate relationship.

During an interview, the AP said she met the resident while working at the facility. The relationship started as friends and then progressed into a sexual relationship. She said the relationship was approved by management. She never considered the resident vulnerable as they were both consenting adults, of similar age. She said she never received money from the resident, but she bought the resident groceries with his money when the resident stayed at her home for ten days.

In conclusion, the Minnesota Department of Health determined abuse 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.

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; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The previous facility ownership directed an erroneous order, direction, or care plan.

(2) The facility was in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP followed the previous facility ownership directive and/or policies and procedures.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

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

Action taken by facility:
The current owners of the facility conducted an internal investigation. The AP no longer worked at the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Fillmore County Attorney
Harmony City Attorney
Harmony Police Department

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		

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
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.	