Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL394852302M
Compliance #: HL394853968C

Date Concluded: July 8, 2025

Name, Address, and County of Licensee Investigated:
Harmony Gardens
1440 County Road C East
Maplewood, MN, 55109
Ramsey County

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

Evaluator's Name: Angela Vatalaro, RN
Special Investigator

Finding: Inconclusive

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), a facility unlicensed personnel, physically abused the resident when the AP slapped the resident's face.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Due to conflicting accounts of the incident, it could not be determined whether physical abuse did or did not occur. The resident reported the AP slapped her face and the AP denied the allegation. There was no physical evidence the AP slapped the resident, no witnesses to the alleged incident, and no camera in the resident's room.

The investigator conducted interviews with facility staff members, including administrative and nursing staff. The investigation included review of the resident records, facility internal investigation, facility incident report, personnel file, staff schedules, law enforcement report,

and related facility policy and procedures. Also, the investigator observed staff interaction with the resident and staff interactions with other residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included amyotrophic lateral sclerosis (ALS, nervous system disease), and anxiety. The resident required hands on assistance of one staff with transfers. The resident was alert, oriented, and made her needs known. The resident was easily overwhelmed, became fearful, which led to crying spells. The resident at times had acute anxiety and crying spells that made the resident unable to do things or communicate effectively. The resident also received contracted hospice services.

The resident's record indicated the resident was admitted to a specialized area of the facility from a different floor the night of the alleged incident.

The facility internal investigation indicated the first full day in the new living area; the resident told a contracted staff that the AP slapped the resident's face.

During the facility investigation, the resident stated during the overnight shift she asked the male overnight unlicensed personnel (AP) to assist her out of bed into her recliner. The resident stated the AP had grabbed her to help her up, the resident said she pushed the AP's hand out of the way, and the AP responded by slapping the resident's face. The resident stated the AP may have slapped her right cheek however she did not remember. The resident stated the incident occurred around 2:00 a.m. and the AP did not come back to the room after the incident. When leadership asked if this occurred intentionally, the resident said, "well yeah" and began crying. The resident stated the AP wanted her to shut up and had asked her "What do you need? Why are you crying?" when the AP came into the room. Leadership did not see noticeable redness, bruising, or swelling.

During the facility investigation, the AP stated the resident had yelled and pushed his hand while he attempted to assist the resident out of bed. The AP stated the resident hit him in the face, and later in the shift the resident apologized. The AP stated he told the resident he was there to care for her, and she did not have to hit him. The resident became very emotional and was crying during shift. The resident had a history of crying. The AP stated when he tried to assist the resident in the past, the resident had not allowed him in the resident's room, and stated the resident did not like the AP.

During the facility investigation, the morning unlicensed personnel, stated when she arrived to shift at 6:00 a.m., the resident was ready to get out of bed. The resident was in a pleasant mood, and did not have any signs of bruising or redness. Throughout shift the resident did not report anything occurred with the AP, and the resident did not have any complaints of pain, swelling, redness, or bruising.

During the facility investigation, multiple unlicensed personnel reported the resident had a history of striking out at staff. One unlicensed personnel stated the resident had a history of not

wanting the AP to assist her during the overnight shift when the resident lived on a different floor of the facility.

During the facility investigation, other residents were interviewed. None reported any concerns with the AP's care or interactions with the AP during the overnight shift.

The resident's record indicated a licensed nurse assessed the resident's skin due to the reported incident. There was no bruising, swelling on the resident's cheek area, or reddened marks. The resident denied any physical pain.

The facility reviewed camera footage from a hallway outside the resident's room. The footage showed the AP entered the resident's room a total of four times; at 10:55 p.m., for a minute or less. at 12:18 a.m. until 12:21 a.m., at 12:25 a.m. until 12:31 a.m., and at 3:57 a.m. until 4:02 a.m.

The facility was unable to determine what occurred in the resident's apartment behind closed doors. The facility contacted law enforcement to report the incident. The resident chose not to meet with law enforcement.

The law enforcement report indicated the facility contacted law enforcement and reported the incident.

During an interview, a contracted unlicensed personnel stated the resident reported to her that the facility male overnight unlicensed personnel (AP), had slapped the resident's face when the resident requested to be transferred from her bed to her recliner. The resident said she "shooed" the AP's hands away and the AP then slapped the resident's face. The contracted staff stated there were no noticeable marks visible on the resident's face. The resident was visually upset and crying.

During an interview, a nurse stated the resident required staff assistance with transfers and was alert and oriented. The nurse stated after the resident reported the incident, a licensed nurse assessed the resident's skin. The nurse stated the resident did not have red marks, no injuries, or complaints of pain. The nurse stated the resident had prior and ongoing extreme crying episodes that the resident could not control due to ALS disease.

During an interview, leadership stated when she spoke to the resident the resident said it was the male unlicensed personnel working overnights that slapped her. Leadership stated the AP was the only male overnight unlicensed personnel working and was viewed on the facility hallway cameras entering and exiting the resident's room. Leadership stated the AP denied the allegation. The alleged incident occurred on the first night the resident moved to a specialized area at the facility and the AP worked in the specialized area. Leadership stated the resident had requested assistance from the AP with a transfer. Leadership stated there were no physical signs of injury and there was no video evidence of the incident from the resident's room.

During an interview, the AP stated he went into the resident's room to assist the resident to get up out of bed. The resident was crying, which was not abnormal for the resident. The AP stated the resident declined the AP's assistance and help. The AP denied slapping the resident's face.

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; 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.

Vulnerable Adult interviewed: No. Declined.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation and contacted law enforcement. The AP is no longer employed at 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
	39485	A. BUILDING: _____ B. WING _____	C 06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY GARDENS	1440 COUNTY ROAD C EAST MAPLEWOOD, MN 55109

(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 On June 25, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL394853968C/#HL394852302M. No correction orders are issued.	0 000		