Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL394855243M
Compliance #: HL394858902C

Date Concluded: January 24, 2024

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: Jennifer Segal RN, BSN
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), unknown facility staff, financially exploited Resident #1 (R1), Resident #2 (R2), and Resident #3 (R3) when the AP stole the resident's rings.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. Resident #1's wedding ring went missing from her finger. Resident #2 had a diamond ring missing from her apartment. Resident #3's wedding ring went missing from her finger. Based on a preponderance of evidence, the AP, a facility staff, took R1, R2, and R3's rings. The AP had recently worked with the residents, was described by resident #1 as the person who took the ring and was seen on video surveillance as the last staff to exit resident #3's apartment prior to the ring missing. In addition, the AP was previously determined to be responsible for financially exploiting a vulnerable adult when the AP took $25,000.00 from a resident who resided at a facility the AP was employed at.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted law enforcement. The investigation included review of resident's medical records, facility investigations, staff schedules, the AP's employee file and facility policy and procedures.

Resident #1 lived in the memory care unit of the assisted living with diagnoses including dementia. R1's service plan indicated the resident required assistance with all personal care and staff checked on the resident hourly. R1's assessment indicated she was vulnerable and at risk of abuse and financial exploitation due to community living setting.

Resident #2 lived in an assisted living apartment with diagnoses including diabetes and kidney disease. R2's service plan included assistance with all personal cares including medication management.

Resident #3 lived in the memory care unit of the assisted living with diagnoses including dementia. R3's service plan included assistance with all personal care and staff checked on the resident every two hours. R3's assessment indicated she was vulnerable and at risk of abuse and financial exploitation due to community living setting.

A facility investigation indicated R1 was in the hallway at 6:30 a.m. looking for a woman who was in her room at 4:00 a.m. and stole her wedding rings. The facility investigation indicated staff searched for R1's rings and initiated an investigation. The facility investigation indicated multiple staff spoke with R1 regarding her missing rings. R1's recollection of the incident was consistent when describing a woman stole her rings at 4:00 a.m. The facility investigation indicated two staff worked the overnight shift, the AP, and another unlicensed staff. When interviewed the AP stated R1 slept through the night. The AP stated when she checked on R1 at 4:00 a.m., the resident was "bundled up" and sleeping so the AP didn't notice if the resident had rings on. The other unlicensed staff working that night stated she did not work in memory care that night. The investigation indicated R1s ring was not found, and the facility was unable to determine how the rings went missing.

The staff schedule for the overnight shift when R1's rings went missing indicated the AP worked alone in the memory care unit, and another unlicensed staff was scheduled to work in the assisted living.

R1's service delivery record indicated the AP documented providing reassurance checks throughout the night R1's rings went missing. The AP documented checking on R1 at 4: 00 a.m.

During an interview, R1s family member stated he was aware R1 was missing her wedding rings, however, it could not be determined if the ring was misplaced or if someone took it.

Six weeks later, a facility investigation indicated resident #2 stated she was missing a diamond ring that was in a wooden box and kept in her bedroom dresser drawer. R2 saw the ring 4-5 days prior to it missing. The facility investigation indicated the resident's family member stated they saw the ring inside the wooden box in the resident's bedroom dresser drawer about 4-5 days prior. R2 and her family searched for the ring and could not locate it.

The staff schedule reviewed over five days including all shifts and prior to R2 noticing her ring was missing indicated the AP worked in the facility five out of the five days reviewed.

R2's service delivery record indicated the AP documented providing several personal cares to R2 throughout the morning, afternoon and evening three out of five days reviewed.

The facility investigation indicated several residents and staff members were interviewed and stated no other missing items were identified, and no one knew about R2's missing ring.

A police report indicated a report of theft at the facility was made when R2's diamond ring was missing from her apartment. The police report indicated the AP worked during the time R2's ring was missing and was working when R1's ring went missing. The report indicated when law enforcement interviewed R2 and family she stated she did not remove the ring from the wooden box in the drawer, because she does not wear the ring and insisted it was last seen in the ring box inside the drawer.

When interviewed R2 stated another family member held the ring in a safe because it held such special meaning. R2 and family decided to gift the ring to another family member and asked the family member securing the ring to bring it to R2s apartment. They placed the ring in a wooden box and put it in a dresser drawer for safe keeping for a short time until she was able to gift the ring. 4-5 days before she planned to give the ring to her family member R2 discovered the ring was missing. R2 stated the wooden box was in the drawer, but the ring was not in the box. R2 stated family and police went through everything searching for the ring. R2 stated the facility staff have keys to the apartment and they provided frequent care.

Four months later, a facility internal investigation indicated resident #3's family notified management R3 was missing her wedding ring. The family stated she visited R3 the prior evening and saw the wedding ring on R3's finger. When family asked R3 where her wedding ring was, R3 stated a short woman was in her apartment and took the wedding ring off R3's finger during the night.

The facility investigation indicated they reviewed video from the hallway from the time R3's rings were discovered missing. R3 was observed wearing her wedding ring at approximately 5:15 p.m. The resident was observed at 7:56 a.m., approximately 15 hours later, with no wedding ring on her finger. The investigation indicated only two staff members had access to R3's apartment during the time the ring went missing. The AP worked alone that night and the other person with access to R3's apartment reported the missing ring.

The staff schedule over the fifteen hours R3's wedding ring went missing the AP was scheduled to work in the memory care unit alone and another unlicensed staff was scheduled to work in the assisted living.

R3's service delivery record indicated the AP documented providing reassurance checks every two hours throughout the night.

During interview R3's family stated R3 wore her wedding ring all the time she never removed it. The family stated when they visited the following day and noticed R3 without her wedding ring it was unusual. When family asked R3 what happened to her wedding ring R3 said a woman removed her wedding ring from her hand during the night.

During interview the facility leadership stated they concluded the AP likely took the rings based on information they obtained from law enforcement, commonalties of the two previous incidences of missing rings and facility video surveillance showed the AP was the only staff member to go in or out of R3's apartment during the time frame the ring went missing. The facility stated the AP is no longer employed at the facility and the facility has not had any more reports of missing items.

The Police report indicated at approximately 5:22 a.m. the AP was observed on video going into R3's room and came out with a garbage bag. At 5:39 a.m., 17 minutes later, the AP entered R3's room and was seen exiting the room 8 minutes later. After the AP came out of R3's room the AP was observed walking to the bathroom, and then walks back to where the AP's personal items are kept.

When interviewed law enforcement indicated charges were pending for the theft of the rings and was currently under review with the county. Law enforcement indicated multiple attempts were made to interview the AP and were unsuccessful. Law enforcement indicated the AP had history of financial exploitation. Approximately one year ago the AP admitted and was charged with forgery and cashing a check for $25,000 when she had stolen from another vulnerable adult. In addition, law enforcement indicated the AP had history of pawning jewelry including rings.

The investigator was unable to locate the AP for interview. Multiple phone numbers, email addresses and texts were sent without response. Law enforcement indicated they were unable to locate the AP at her last known address. During the past MDH investigation the AP was also unable to be located.

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

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: R1-unable, R2- yes, R3- deceased.
Family/Responsible Party interviewed: R1 yes, R2 not applicable, R3 yes
Alleged Perpetrator interviewed: No, unable to locate.

Action taken by facility:
The facility investigated the missing rings, installed additional video surveillance, contacted authorities, made required reports, and provided additional staff training.

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.

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
Ramsey County Attorney
Maplewood City Attorney
Maplewood Police Department

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 11/27/2023

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 ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order is 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: #HL394855243M, #HL394858902C On Novemeber 27, 2023 the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 37 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL394855243M, #HL394858902C, tag identification 2360.	0 000	No plan of correction is required for this tag.	
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.	02360		

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HARMONY GARDENS	1440 COUNTY ROAD C EAST MAPLEWOOD, MN 55109

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure three of three residents reviewed (R1, R2 and R3) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, 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		