Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL215181361M
Compliance #: HL215182302C

Date Concluded: February 7, 2023

Name, Address, and County of Licensee Investigated:
Harmony Place
455 Main Avenue North
Harmony, MN 55939
Fillmore County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Zalei Lewis, RN
Special Investigator

Carrie Euerle, MSN, RN

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):
An unlicensed facility staff member/alleged perpetrator (AP) verbally and physically abused the resident when the AP yelled at the resident, dragged the resident down the hallway, and forcefully pushed the resident on to a chair.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. There is not enough evidence available to support if abuse occurred. Staff who worked at the time of the incident, including the witness and the alleged perpetrator (AP), were not available for interview.

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

records, facility records, policies, and procedures. At the time of the onsite visit, the investigator completed observations of the environment, staff interaction with residents, and cares provided at the facility.

The resident resided in an assisted living with dementia care facility. The resident's diagnoses included dementia and Parkinson's disease. The resident's service plan included assistance with activities of daily living, medication management, and behavior monitoring. The resident's assessment indicated the resident could communicate verbally, had trouble with word finding, required staff to provide cues, reminders, redirection, and assistance with completion of daily cares.

The alleged incident occurred when the AP assisted the resident from the dining room to the living room. The resident was slow with ambulation and shuffled her feet when walking. The AP was allegedly observed dragging the resident, instead of allowing time for the resident to walk. The AP then directed the resident towards a chair, where the resident refused to sit. The AP forcefully pushed the resident on to the chair and began to repeatedly yell at the resident to "sit down".

The incident was reported to facility management. Facility management immediately suspended the AP and began an internal investigation. There was no camera footage available of the area where the alleged incident occurred. The internal investigation identified one witness to the event. The witness felt that the AP used force when putting her hands on the resident to assist her from the dining room to the chair and indicated the AP often spoke to residents in an aggressive manner. Additional staff interviewed could provide no further information or details about the alleged incident. The AP was interviewed by facility management and denied abusing the resident. The resident did not recall the incident but reported to her family that a staff member had "pulled her hair". The resident sustained no injuries.

Attempts to interview staff who worked at the facility at the time the alleged incident occurred were unsuccessful. The witness and AP did not respond to requests for interview. Staff working at the time of the onsite visit, were not familiar with the incident.

In conclusion, the Minnesota Department of Health determined neglect 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: No
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Attempts to contact the AP were unsuccessful.

Action taken by facility:
The facility immediately suspended the AP, reported the incident and began an internal investigation. Following the incident, all staff were retrained on caring for resident's with dementia.

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 02/03/2023

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 On February 3, 2023, the Minnesota Department of Health initiated an investigation of complaint HL215181361M/HL215182302C. No correction orders are issued.	0 000		