Protecting, Maintaining and Improving the Health of All Minnesotans

H54166383M

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306131461M
Compliance #: HL306132342C

Date Concluded: May 14, 2025

Name, Address, and County of Licensee Investigated:
Milestone Senior Living Faribault
2500 14th St. NE
Faribault, MN 55021
Rice County

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

Evaluator's Name: Deb Schillinger RN BSN
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 facility neglected resident #1 and resident #2 when supervision was not provided and resident #1 groped resident #2.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated.

Resident #1: Although it was true resident #1 groped resident #2 and there may have been an initial miscommunication between an unlicensed caregiver and the manager, the facility took appropriate actions to ensure there was no injury and took steps to reduce the risk of recurrence.

Resident #2: Although it was true resident #1 behaved touched himself and groped resident #2, the facility took appropriate action to redirect resident #1 when it occurred. Resident #1 had been recently admitted and had not behaved in this way before at the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed interactions between facility staff and residents within the memory care unit.

Both resident #1 and resident #2 lived in an assisted living memory care unit.

Resident #1
The resident's diagnoses included dementia and depression, who had been recently admitted to the facility. The resident's service plan included assistance with medication management and administration, assuring the resident dines with male residents, and hourly safety checks. The resident's assessment indicated the resident was oriented to self only and ambulated independently using a wheeled walker.

Resident #2
The resident's diagnoses included Alzheimer's disease and anxiety. The resident's service plan included assistance with medication management and administration and hourly safety checks. The resident's assessment indicated the resident was disoriented, but able to ambulate independently with a walker. The resident also received hospice services.

The facility's internal investigation indicated an unlicensed caregiver witnessed resident #1 touching himself and groping resident #2's breast, over her clothing in a public area. After separating the residents, the unlicensed caregiver reported the incident to a manager regarding resident #1's touching himself but indicated the manager did not realize was also resident #2's involved. At the time, the manager instructed the unlicensed caregiver to redirect resident #1 back to his room and to write a communication note to alert the nurse of the incident. The unlicensed caregiver wrote the note to alert the nurse of the incident with information including the involvement of resident #2, which the nurse received the following day. The nurse completed an assessment of resident #2 the following day and found no injury, nor was the resident able to recollect the incident.

During an interview, the manager stated a phone call was received regarding the incident, however the manager stated information regarding resident #2 was not discussed during the phone call. The manager stated when the information was presented the following day, the process was followed, including notification of the nurse who assessed resident #2 for injury.

During an interview, the nurse stated upon notification, resident #2 was assessed and no injury was identified. The nurse also notified the medical provider, and the plan of care was adjusted for resident #1. The nurse stated service plans were updated for both residents and new interventions were added.

The investigation included attempts to interview the unlicensed caregiver who witnessed this event, but those attempts were unsuccessful.

In conclusion, the Minnesota Department of Health determined neglect 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: no, both with cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not applicable

Action taken by facility: Individual Abuse Prevention Plans were updated for both residents and reeducation provided to all unlicensed caregivers on vulnerable adult abuse.

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
	30613	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING FARIBAULT	2500 14TH ST NE FARIBAULT, MN 55021

(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 May 6, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL306132342C/#HL306131461M. No correction orders are issued.	0 000		