Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306259948M
Compliance #: HL306258145C

Date Concluded: April 29,2024

Name, Address, and County of Licensee Investigated:
Northern Oaks Place
1005 Paul Parkway NE 7
Blaine, MN 55434
Anoka County

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

Evaluator's Name: Brandon Martfeld, 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):
An unknown facility staff member sexually abused the resident when the staff member touched the breast of the resident in front of the resident's family members. After some of the family members left, the staff member returned and touched the resident's breast two more times. In addition, the resident had a fall and bruising to both wrists.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. During the investigation an alleged perpetrator (AP) was identified. Although the AP displayed inappropriate behavior by touching the resident's breast, the behavior did not rise to the level of abuse. In addition, while supervised by a facility staff member, the resident fell while walking in the facility. The facility arranged for a wheelchair following the fall.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and the AP. The investigator contacted law enforcement and the

case worker. The investigation included review of the resident records, death record, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed staff interactions with the residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with dressing and grooming. The resident was severely cognitively impaired, required supervision from staff when transferring and used a walker to assist with ambulation. The resident was vulnerable to abuse and staff were trained to observe the resident for signs of abuse and neglect.

The facility's incident report indicated one day the resident's family members witnessed the AP touch the resident's breast. When asked by leadership about the incident, the AP said she touched the resident's breast to be funny. A facility nurse educated the AP about professional boundaries of joking and touching the resident. The family of the resident did not want any disciplinary action against the AP because there was no ill will or intent to harm or abuse of the resident.

During an interview, the facility nurse stated the AP was interviewed about the incident with the resident. The AP had lifted the resident's breast from the bottom and made a comment about how large the resident's breast were. The facility nurse stated it was a joke between the resident and the AP.

During an interview, the regional director of operations stated the AP had developed a strong relationship with the resident and did not maintain professional boundaries. The resident liked to dance, sing, and joke, and the AP often danced, sang, and joked with the resident.

During an interview, the AP stated the resident had clothes on and that she touched the underside of the resident's breast over the clothes just the one time. The AP stated the resident liked to joke and made comments about the AP's large breasts. The AP stated she was joking with the resident when she touched the resident's breast and said you have a bra on.

During an interview, a family member stated after the incident, the resident just laughed. The family member stated they had no concerns with the AP's treatment of the resident. The family member also stated they did not have concerns with the resident's fall.

The additional concern of the resident's fall was investigated. A facility incident report indicated the resident was supervised by an unlicensed staff member when she became dizzy, fell backwards, and hit the back of the resident's head. The resident sustained a cut to the back of the resident's head, staff applied a dressing to the area, and updated the resident's hospice provider. The hospice provider arranged for the resident to use a wheelchair for mobility. There was no evidence in the resident's record of bruising of the resident's wrists.

In conclusion, the Minnesota Department of Health determined abuse 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.

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;
(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; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(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. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Education was provided to the AP about maintaining professional boundaries.

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
	30625	A. BUILDING: _____ B. WING _____	C 04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN OAK PLACE	1005 PAUL PARKWAY NE BLAINE, MN 55434

(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 April 15, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL306259948M/#HL306258145C. No correction orders are issued.	0 000		