Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL30638005M
Compliance #: HL30638006C

Date Concluded: August 3, 2022

Name, Address, and County of Licensee Investigated:
Ecumen North Branch
383rd St. 19
North Branch, MN 55056
Chisago County

Evaluator's Name:
Jana Wegener, RN, Special Investigator

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

Finding: Substantiated, individual responsibility

Nature of Visit:
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) abused the resident when he repeatedly kissed the resident, rubbed her shoulders and stroked her arms in a seducing manner, and had recurring inappropriate sexual conversations involving oral sex, sexual interactions, sexual orientation, and the AP's sexual preferences. As a result, the resident felt anxious, fearful, mentally distressed, and had difficulty sleeping with nightmares of being raped.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined based on a preponderance of evidence the abuse was substantiated. The AP was responsible for the maltreatment. The AP admitted having repeated inappropriate sexual conversations with the resident. The resident stated because of the AP's inappropriate conduct the resident began having difficulty eating, sleeping,

and had recurring nightmares of being raped. The resident was diagnosed with a nightmare disorder and received medications. In addition, during the investigation other potential concerns were identified regarding the AP having sexually inappropriate conduct with other residents who resided in the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, and the resident's family. The investigation included observations, a review of resident records, employee records, and facility policies and procedures.

The resident was admitted to the facility with diagnoses including stroke with left sided weakness, anxiety disorder, and depression. The resident was oriented to person, place, and time. The resident required physical assistance from one staff for mobility, ambulation, dressing, bathing, toileting, and incontinence care.

Shortly after the AP started working at the facility and providing cares to residents independently, the resident's progress notes indicated she reported having difficulty sleeping for about a week.

The AP's schedule and resident's services delivered record indicated the AP had worked several shifts with the resident. The AP documented providing cares to the resident including medication administration, dressing, transferring, toileting, and incontinence cares.

The resident was seen by a medical provider shortly after the resident told staff she was having difficulty sleeping. The residents after visit summary (AVS) indicated the resident had reported to her provider she was having very scary nightmares. The provider indicated the nightmares affected the resident's mood and wellbeing, and recommended the resident try medication to help. The resident's record indicated she was diagnosed with a new onset of a nightmare disorder and prescribed Parazosin medication for nightmares.

One evening, about three weeks later, the resident reported to two unlicensed staff she was a nervous wreck and the AP made her feel uncomfortable. The resident told staff she was afraid of the AP, and never wanted him to take care of her again. Staff asked the resident to elaborate, and the resident reported the AP would say he has had "a bad day" and tells the resident "A hug would be nice, but a kiss would be better". The resident stated the AP had kissed her on the forehead and neck several times. The resident stated when the AP answered her call light and cancelled her pendant he lingered too long and pointed at her chest. The resident reported the AP touched and kissed her and would come into her room and hang out. The resident stated she was scared of the AP. The resident stated one day while seated at the kitchen table the AP was talking to the resident about having intercourse with men and women and oral sex with both. Then, the AP stood up and the resident stated the AP appeared to have an erection she could clearly see through his pants. The resident told the AP to leave. The

resident told staff after that incident when her dog barked, she was afraid the AP was coming into her room.

The facility investigation documented interviews with the resident who went into more detail and became emotional when talking about interactions with the AP and cried as she described the incidents. The resident stated the AP would touch her and linger at her breasts when he would clear her call pendant button. The resident stated the AP came in her room when she was in bed and stated he was "having such a bad day and could use a kiss". The resident stated she kissed the AP on his neck, and after that the AP became more and more aggressive and kissed her forehead, would stand too close, touched her too much, and would rub her shoulders in a seducing manner that made her feel uncomfortable. The resident stated she began having trouble sleeping, eating, and started having nightmares because of the AP's interactions with her.

A facility email from a nurse a few days later reported the resident stated she was having nightmares about being raped, and reported to staff it had taken her a month to report the AP.

The same day another facility staff email indicated the resident was tearful throughout the day and was observed crying in the dining room and stated she felt ashamed.

A staff communication the same day indicated when talking to the resident about her concerns the resident stated she continued to relive the incidents and was having recurring nightmares. The resident talked about the AP standing up and showing the resident he had an erection, and stated the AP wanted her to see it. The resident reported she was worried about other residents in the facility

Another email communication from facility staff indicated the resident was upset and crying and reported being victimized by the AP and was not able to eat, sleep, and did not understand why the AP would want "an old woman." The resident described an incident when the AP fell on top of her and held himself up with his hands and the resident screamed. The resident stated when she screamed the AP pretended like he fell and got up.

A provider AVS the following day indicated the resident told the provider she was dealing with "personal issues" and when going further into details the resident became very tearful and stated she was "sexually assaulted by a staff member". The resident reported feeling safe in her apartment since the AP was no longer in the facility, however, she was still having nightmares as a result of the incident. The AVS indicated the resident's nightmares had improved some since reporting the incident and told the provider she felt like a weight was lifted off her shoulders to know the AP could not hurt anyone anymore.

The facility investigation included interviews with the AP who stated he enjoyed the resident's company, and if the resident was in a bad mood they would "talk it out" and the conversation would go "who knows where". The AP stated the resident talked about having a better life,

with a better male counterpart than her previous husband, a guy like him. The AP stated he had kissed the resident on the forehead, hugged her, and discussed his sexuality. The AP stated he was unsure if he had discussed oral sex with the resident but would not be surprised if he had. The AP stated he had sexual conversations with the resident that were not appropriate, and indicated their conversations strayed. During the facility interview the AP mentioned another resident (resident B) who the AP reported had done her best to “cross boundaries with him” and would “act like a pretty princess all the time” by “sitting pretty in her bed and never cover anything up”. The AP stated resident B “was comfortable with him in a way that she was with her husband” and the resident wanted him to care for her as much as possible. The AP stated 75 percent of resident B’s communication was body language and the other part was resident B telling the AP he was “handsome”.

The facility investigation indicated resident B was not interviewed because the resident had died weeks prior to the AP’s statements about his relationship with resident B. A review of resident B’s record indicated she was receiving hospice end of life care and was actively dying when the AP felt the resident was trying to “cross boundaries with him” by “sitting pretty on her bed uncovered”. The resident record indicated the AP had documented providing cares for resident B including dressing, toileting, and incontinence care prior to her death.

The facility investigation indicated resident C was interviewed and stated nothing inappropriate happened when the AP assisted her with her shower, however, the resident stated she was afraid when the AP was working if her shower was due. A review of resident C’s record indicated she required assistance with dressing and bathing and indicated the AP had documented providing cares for the resident including bathing. When the facility asked the AP about resident C’s statement, The AP stated resident C was not a fan of male staff but was ok with the AP when he assisted her with a shower and the resident did not seem uncomfortable.

When interviewed by the investigator the AP stated he frequently had sexually inappropriate conversations with the resident. The AP stated he talked to the resident about his sexual preferences, experiences, and things he was not proud of. The AP stated he felt like the resident was not in a very good place mentally and indicated he felt the resident had a difficult life, and he must have seemed like a nice young guy. The AP stated his relationship with the resident was closer than other residents because she trusted him. The AP discussed the process for applying topical medication to the resident’s shoulders for pain relief, and stated he felt like the resident regularly took her blouse down in a sexually suggestive manner. The AP stated when turning off the resident’s pendant call light it took a while because he had to hold the pendant in his hands and press the button multiple times, then wait for it to clear, and press it again. The AP stated there was a lot of face-to-face time while resetting the resident’s pendant call light. The AP stated he gave the resident side hugs and nudged her with his face and stated the resident may have interpreted that as some sort of kiss. The AP denied feeling aroused at work, and stated he was on several medications that prevented an erection. The AP stated he carried two phones and keys in his front pockets and indicated in dim light, to a resident who was interested in him, he could see how it may have appeared to the resident he had an

erection. The AP stated he felt resident B was very flirty with him, but she was not strong enough to do anything.

When interviewed by the investigator the resident was tearful and visibly upset with her hands covering her face as she cried, and repeatedly stated “Why would he do this to me”? The resident stated the AP was forward with her from day one and made her feel uncomfortable when he would rub her shoulders and arms and touch her for a long time in a way that made her feel very uncomfortable. The resident stated she had to move away from the AP to get him to stop what he was doing. The resident stated the AP had repeated conversations with her about having sexual relations with men and women. The resident stated the AP made her feel scared and afraid. The resident described a time when the AP sat at her table talking about sexual things, and when he stood, she saw he had an erection. When asked if what she saw could have been mistaken for keys, phones, and other things in the AP’s front pockets, the resident stated the AP unmistakably had an erection. The resident stated she never locked her door before that but started locking it to feel safe. The resident stated, “I got away from him, he is not here anymore”. The resident stated the facility told her the AP would never bother her again and indicated she could not talk about it anymore.

Interviews with the resident’s family and facility staff indicated the resident had no issues with sleep or nightmares prior to the AP working with her.

During email communication with facility leadership, they indicated the resident had a pendant call light that used a magnet to quickly turn it off, and it should only take staff one to five seconds to reset the pendant call light. The email indicated there was a backup way to reset the pendant call light that took considerably longer, up to 15 seconds requiring staff to press the button multiple times. The email indicated the AP always had access to a magnet to quickly turn off the resident’s pendant call light, and there were no issues ever reported using the magnet to turn off a pendant call light that would have required the AP to use the backup method.

At the time of the investigation the resident continued to require medication for the nightmare disorder, and supportive services following the incident with the AP.

In conclusion, abuse was substantiated.

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:
(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;
(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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Facility staff immediately reported the resident's allegation of abuse to leadership. The AP was promptly walked out of the facility and suspended pending investigation and is no longer employed by the facility. The facility investigated the resident's allegations by interviewing other resident in the facility and staff. The resident was provided additional supportive services following the abuse.

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.

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
Chisago County Attorney
North Branch City Attorney
North Branch Police Department

Department of Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30638	A. BUILDING: _____ B. WING _____	C 07/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN NORTH BRANCH	5379 383RD STREET NORTH BRANCH, MN 55056

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are 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: #HL30638005M/ #HL30638006C On July 5, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order was issued. At the time of the complaint investigation, there were 74 resident's receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL30638005M/ #HL30638006C, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the licensee failed to ensure one of one residents (R1) reviewed were free from maltreatment. R1 was abused. Findings include: On July 5, 2022, the Minnesota Department of Health (MDH) issued a determination that abuse occurred for R1, and a individual was responsible for the maltreatment in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	