Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307457706M
Compliance #: HL307454524C

Date Concluded: September 25, 2023

Name, Address, and County of Licensee Investigated:
Lino Lakes Assisted Living
725 Town Center Parkway
Lino Lakes, MN 55014
Anoka County

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

Evaluator's Name: Julie Serbus, RN
Special Investigator
Paul Spencer, RN
Special Investigator

Finding: Substantiated, facility 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 facility neglected resident #1 and resident #2 when resident #2 touched resident #1 sexually.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Although concerns regarding the relationship between resident #1 and resident #2 arose on multiple occasions, the facility did not assess nor implement subsequent interventions to address these concerns for either resident. Resident #2 touched resident #1 sexually, which resident #1 said was not welcome.

The investigator conducted interviews with the vulnerable adult, facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted

law enforcement and the resident's family member. The investigation included review of the resident's facility records including assessments, medical provider notes, and facility notes.

The Incident
A facility note titled Possible Abuse indicated an unlicensed caregiver found resident #2 in a female resident's bedroom. The same document indicated the female resident said resident #2 threw her in bed and touched her all over her body. On the same day, resident #2's progress notes identified the female resident involved in this incident as resident #1.

Resident #1
Resident #1's diagnoses included impaired cognition with progressive decline and Alzheimer's disease. She had lived at the facility for approximately eight months prior to the incident described above.

Approximately eight months prior to the incident, resident #1's Individual Abuse Prevention Plan indicated she was not oriented to time, place, and person. The same document indicated she was not susceptible to abuse from another individual, including other vulnerable adults. The same document indicated she had not demonstrated inappropriate sexual behavior.

Approximately four months prior to the incident, resident #1's assessment indicated she was not always oriented to person, place, or time.

A review of resident #1's medical record indicated the next time the facility updated the resident's assessment or Individual Abuse Prevention Plan was approximately two weeks after the incident described above took place.

Resident #2
Resident #2's diagnoses included impaired cognition. His admission assessment indicated he was oriented to person, place, and time with varying disorientation. The same document indicated he had memory problems and had impaired decision-making. He admitted to the facility approximately two months prior to the incident described above.

A review of resident #2's medical record did not identify an Individual Abuse Prevention Plan upon admission to the facility.

Approximately six-and-a-half weeks prior to the incident described above, resident #2's Aggressive Behavior note indicated an unlicensed caregiver found resident #2 in a female resident's room. The same document indicated the female's shirt was up. When the unlicensed caregiver asked what was happening, resident #2 stated he was just "having a conversation." The unlicensed caregivers asked him to leave. The document indicated the female resident told the unlicensed caregiver resident #2 was pulling up her shirt and trying to get her to get into bed with him. The same document indicated the female resident expressed resident #2 made her feel "uncomfortable".

During the course of the investigation, it was confirmed that the female resident on this occasion was resident # 1.

Approximately six weeks prior to the incident described above, resident #2's progress notes indicated a member of the management team spoke with him about another resident's [resident #1] concerns about him being in her room. The same note indicated the other resident said she was uncomfortable and did not want him in her room again.

A review of resident #2's medical record did not identify any new assessments or subsequent interventions at the time of these events.

Approximately two weeks prior to the incident described above, resident #2's Aggressive Behavior note indicated resident #2 took another resident into his room after he went to her door and asked her to go on a walk with him. The same note indicated an unlicensed caregiver knocked on resident #2's door but he would only open the door halfway and would not let the caregiver see the other resident. The same note indicated the residents were not to be in each other rooms and management was notified.

A review of resident #2's medical record did not identify any new assessments or subsequent interventions at the time of these events.

Approximately six days prior to the incident described above, resident #2's progress notes indicated a member of the management team spoke to him regarding resident #1. The note indicated resident #2 was informed resident #1's family did not wish him to be in her room.

Approximately five days prior to the incident described above the facility completed an Individual Abuse Prevention Plan for resident #2. The same document indicated he was not a risk to abuse other vulnerable adults. The same document did not include any new interventions to address to address the relationship between resident #1 and female residents.

On the day of the incident, resident #2's progress notes indicated he was found in resident #1's room and he was told to leave. The same note indicated she said he threw her on the bed and touched her all over. The same note indicated resident #2 was no longer in the building.

Interviews

During an interview, resident #1's family member stated they have voiced concerns about resident #1's and resident #2's relationship to the facility. On one occasion, while visiting resident #1 a family member found resident #2 in her apartment. The family member stated the visitor attempted to voice their concerns to administration, but they were not available, so they approached resident #2 and asked him to not visit resident #1 in her apartment and resident #2 said he understood, however they also followed up with facility management to express their concerns. A little over a month later resident #1 stated to her family she does not

feel comfortable going into the dining room. The family stated they called administration to report resident #1's fears and administration stated they would speak with resident #2.

During an interview, a member of the facility administration stated within days of resident #2's admission to the facility he was in resident #1's room and family requested resident #1 not have male residents in her room. She stated facility administration said they would do their best to see others do not enter her apartment. There are no electronic devices in the hallways and staff members were aware resident #2 would sneak into resident #1's room.

During an interview, unlicensed caregiver #1 stated one day resident #1 had not come down for the meal or to the medication cart to get her medications, which was unusual. When she found resident #1 in her apartment, resident #2 was there sitting in a chair with resident #1 in front of him while he was holding up her shirt. Unlicensed caregiver #1 ask if resident #1 was okay and she shook her head "no" and the unlicensed caregiver asked resident #2 to leave. Unlicensed caregiver #1 stated she had been told verbally by facility management that resident #1 and resident #2 were not to be in each other's rooms. She stated she had found resident #2 walking towards resident #1's apartment on multiple occasions and redirected and reminded him he was not allowed in her apartment. On another occasion she witnessed resident #1 exiting resident #2's apartment. Unlicensed caregiver #1 stated resident #2 would have had to escort resident #1 to his apartment because resident #1 would not have gone to the second floor independently [resident #1 lived on the first floor].

During an interview, unlicensed caregiver #2 stated she observed symptoms of resident #1's dementia and that her cognitive status varied. Unlicensed caregiver #2 stated facility management verbally informed caregivers of resident #1's family's wish to not allow males into resident #1's room. She stated that caregivers could not be everywhere and, while there was a medication cart in the hallway not far from resident #1's room, that staff members could not be stay there consistently. On one occasion she entered resident #1's room and found resident #2 there and asked him to leave. Unlicensed caregiver #2 stated resident #1 appeared terrified and visibly shaken saying that resident #2 had put her on the bed, touched her everywhere and she did not want this.

During an interview, resident #2 stated the day after he moved into the facility, he met resident #1. Resident #2 stated he picked up on resident #1's dementia, he understood how dementia works, and from the time he moved into the facility resident #1 had good days and bad days, but more bad days. Resident #2 stated one day while he was in resident #1's room, resident #1's family member came to visit, and asked resident #2 to leave the apartment. Later that same family member told resident #2 not be visit with resident #1 in her apartment. Resident #2 stated he was also told by facility staff members he was not to go into resident #1's apartment and resident #1 was not to be in resident #2's apartment. Resident #2 stated he was aware of staff watching him, but he continued to go to resident #1's apartment. He stated they kissed on the lips on two separate occasions while in resident #1's apartment. Resident #2 stated on another occasion resident #2 entered resident #1's apartment in the morning,

resident #1 was still in bed, and he “sucked her breasts.” He stated there was a medication cart at times was near resident #1’s apartment but caregivers often moved the medication cart away from there. Resident #2 stated he would like to see resident #1 again and wondered if she would even recognize him due to her dementia. Additionally, resident #2 stated he went into activities five times week located in secured memory care. [The facility has both regular assisted living and secured memory care units]. Resident #2 stated at times resident #1 went with him and other times he would go without resident #1. Resident #2 stated to enter or exit memory care for activities, staff had to let him in. Resident #2 stated there were times when staff allowed him to stay up to an hour in the unit after activities were finished.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statues, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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: Resident #1- No, due to impaired cognition. Resident #2-Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
Administration spoke with resident #2 that he was not allowed in resident #1’s room.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Anoka County Attorney
Lino Lakes City Attorney
Lino Lakes Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30745	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINO LAKES ASSISTED LIVING	725 TOWN CENTER PARKWAY LINO LAKES, MN 55014

(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, 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: #HL307457784M/#HL307454588C #HL307457706M/#HL307454524C On August 17, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 82 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders which were not immediate were issued for: #HL307457706M/#HL307454524C, tag identification 0630 and 2360.	0 000	Minnesota Department of Health is documenting the State 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.	
0 630 SS=G	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to address areas of potential abuse to other vulnerable adults (VA) on the individual abuse prevention plan (IAPP) for two of four residents (R1 and R2) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1: R1 admitted to the licensee on December 19, 2022, with the diagnosis of cognitive decline. R1's IAPP dated December 19, 2022, indicated R1 was not susceptible to abuse from another	0 630		

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0 630	Continued From page 2 individual, including other vulnerable adults and was vulnerable due to inability to report abuse or neglect. This same document indicated R1 has some identified areas of potential vulnerability, but there were no signs of abuse or neglect. Interventions designed to address areas of vulnerability are described on this form and resident care plan. A review of R1's medical record indicated the next date the facility updated R1's IAPP was August 17, 2023. The same document indicated the resident posed a risk to self with inappropriate sexual behavior and inability to understand other's intentions. The same document indicated she was at risk due to not being able to give accurate information consistently. R2: R2 was admitted to the licensee on May 30, 2023, with the diagnosis of impaired cognition. A review R2's admission assessment dated May 30, 2023, did not identify resident's risks and vulnerabilities on the IAPP. R2's Aggressive Behavior note dated June 16, 2023, indicated unlicensed personnel (ULP)-H found R2 in a female resident's room. The same document indicated the female's shirt was up. When the ULP asked what was happening, R2 stated he was just "having a conversation". The ULP asked R2 to leave. The same document indicated the female resident told the ULP-H R2 was pulling up her shirt and trying to get her to get into bed with him. The same document indicated the female resident expressed R2 made her feel "uncomfortable".	0 630		

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0 630	Continued From page 3 During the course of the investigation, it was confirmed the female resident on this occasion was R1. R2's progress note dated Jun 19, 2023, indicated a member of the management team spoke with R2 about another resident's [R1] concerns about him being in her room. The same note indicated the other resident said she was uncomfortable and did not want him in her room again. A review of R2's medical record did not identify any new assessment or interventions at the time of these events. R2's Aggressive Behavior note dated July 15, 2023, indicated R2 took another female resident into his room after he went to her door and asked her to go on a walk with him. The same note indicated a ULP knocked on R2's door but he would only open the door halfway and would not let the ULP see the other resident. The same note indicated the two residents were not to be in each other's room and management was notified. A review of R2's medical record did not identify any new assessments or interventions at the time of these events. R2's progress note dated July 26, 2023, indicated a member of the management team spoke to R2 regarding R1. The same document indicated R2 was informed R1's family did not wish him to be in her room. R2's IAPP, dated July 27, 2023, indicated R2 was not a risk to abuse other vulnerable adults. The same document did not include any new interventions to address the relationship between	0 630		

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0 630	Continued From page 4 R2 and female residents. R2's Possible Abuse note dated July 31, 2023, indicated ULP-C found R2 in a female resident's bedroom. The same document indicated the female resident said R2 threw her in bed and touched her all over her body. R2's progress note dated July 31, 2023, indicated the female resident described in the Possible Abuse note was R1 by referring to her apartment number. The same note indicated R2 was no longer in the building. During an interview on August 17, 2023, at 12:33 p.m., unlicensed personnel (ULP)-C stated R1 and R2 were on every two-hour checks. At mealtimes R1 and R2 sat next to each other in the dining room. ULP-C stated through RTasks notifications R1 and R2 were not allowed in each other's apartments. ULP-C stated R1 had made comments indicating the man with the bag (catheter) scares me [R2]. ULP-C stated R1 was independent with walking and needed reminders for meals. ULP-C stated R2 would go to R1's room before each meal or activity to escort her. ULP-C stated in the dining room R2 sat next to R1. During an interview on August 17, 2023, at 1:14 p.m., ULP-D stated R2 would go to R1's room to escort her to the dining room. ULP-D stated she told R2 it was not his responsibility and staff would provide the reminders for R1. ULP-D stated R2's room is located on the second floor above R1's and there is a stairway near her room which made easy access to R1's room. ULP-D stated R2 would be in the hallway walking towards R1's room and staff members did at times redirect him away. ULP-D stated R2 went	0 630		

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0 630	Continued From page 5 to R1's room on July 31, 2023, after staff discovered R2 was in R1's room and R1 appeared visibly shaken and anxious. During an interview on August 17, 2023, at 3:07 p.m.., community director (CD)-A stated the registered nurse is responsible for completing vulnerability assessments and updating care plans. CD-A verified she was unsure if care plan was updated with the vulnerabilities. During an interview on August 18, 2023, at 9:14 a.m., R2 stated he was aware R1 had dementia, understood how dementia worked, and that R2 had good days and bad days, but more bad days. R2 stated while he was in R1's room one of R1's family members came to visit and asked R1 to leave. That same family member approached R2 later and told him not to visit R1 in her apartment. R2 also stated facility staff members told not he was not to go to R1's apartment and R1 was not to be in his apartment. R2 stated he was aware of staff members watching him, but he continued to go to R1's apartment. R2 stated he and R1 kissed on the lips on two occasions. R2 stated on another occasion he "sucked her breasts". R2 stated he went to activities five times a week in the secured dementia memory care. [The facility has both regular assisted living and secured memory care units]. R2 stated at times R1 went with him and other times he went without R1. R2 stated to enter or exit memory cares, staff had to let him in. R2 stated there were times when staff members allowed him to reamin in memory care up to an hour after activities were finished. A review of R2's medical record did not identify information regarding what supervision R2 required when in the secured memory care unit.	0 630		

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0 630	Continued From page 6 During an interview on August 30, 2023, at 10:00 a.m., family member (FM)-E stated R1 had said say she did not feel comfortable going to the dining room anymore. FM-E stated this was a concern that was shared with the facility management team. The licensee's Individual Abuse Prevention Plan, dated August 1, 2021, indicated the plan will contain a person's susceptibility to abuse by another individual, including other vulnerable adults, the person's risk of abusing other vulnerable adults, and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. The licensee's Vulnerable Adult policy, dated August 1, 2022, indicated the resident's risk of abusing other vulnerable adults within the residence shall be assessed. The vulnerable adult status assessment shall be documented in the clinical record. An IAPP shall be established for each VA for whom assisted living services are provided. The licensee's Bill of Rights policy, dated August 12, 2022, indicated the resident had a right to be free from physical, sexual, and emotional abuse and neglect and all forms of maltreatment covered under the Vulnerable Adults Act. The licensee's Resident Rules & Regulations Handbook "Addendum D," not dated, indicated the resident assessment will be used to develop a Service Plan and ISP. The assessment will be updated within 14 days of move-in, within every 90-days, and with a change of condition. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 630		

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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. This MN Requirement is not met as evidenced by: Citation Text for Tag 2360, Regulation EF5D Based on observations, interviews, and document review, the facility failed to ensure two of four residents reviewed (R1 and R2) were free from maltreatment. R1 was neglected. Findings include: On August 17, 2023, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility 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		