Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307457784M
Compliance #: HL307454588C

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

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 the resident when staff failed to protect the resident from unwanted sexual touch from another resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Resident #1 and resident #2 both reside in the memory care unit and have a routine of sitting next to each other at meals with resident #2 escorting resident #1 back to her room after meals.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members and law enforcement. The investigation included review of facility progress notes, incident reports, service plans, and facility policies. During an onsite visit, the investigator observed interaction between resident #1 and resident #2 along with staff interactions with the residents.

Resident #1
Resident #1 diagnoses included dementia, anxiety, depression, and osteoporosis. The resident's service plan indicated resident #1 was very social and required escorts to meals and activities, hourly safety checks, medication administration, and assistance with cares.

Resident #2
Resident #2 diagnoses included Alzheimer's, depression, and anxiety. The resident's service plan included resident #2 was on hourly safety checks, hard of hearing, and ambulated independently.

A review of both resident #1 and resident #2's progress notes indicated an unlicensed caregiver observed them walking down the hallway together towards resident #1's apartment. Resident #1 walked away as the unlicensed caregiver reached resident #2, who was crying. Resident #2 said resident #1 had touched her breasts and private area.

A law enforcement report indicated facility staff members and family members reported resident #1 and resident #2 eat their meals together and this type of behavior had not occurred before. At the time this occurred the facility experienced a power outage. The report indicated the police attempted to interview resident #1 but she did not demonstrate recall of the occasion.

During an interview, licensed staff reported it was chaotic in the memory care unit during the power outage. Resident #1 and resident #2 had just finished their noon meal when unlicensed caregiver noticed resident #2 escorting resident #1 to her room and went to ensure resident #1 safely returned to her room. The unlicensed caregiver found resident #1 was upset and said resident #2 had touched her inappropriately.

During an interview, a member of administration stated resident #2 usually pushes resident #1 back to her room after meals but never hangs out in her room. The reported behavior is out of character for resident #2 and felt due to the circumstances residents may have felt a little off their normal pattern due to the power outage.

During family interviews, stated they were aware resident #1 and resident #2 sit at the same table during meals but do not socialize in each other's room. No previous reports of this type of behavior have occurred and both residents feel safe, and staff members provide frequent safety checks.

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
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
No action required.

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
	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		