Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL314172806M
Compliance #: HL314174683C

Date Concluded: June 6, 2023

Name, Address, and County of Licensee Investigated:
Elmore Assisted Living
202 East North Street
Elmore, Minnesota 56027
Faribault County

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

Evaluator's Name: Danyell Eccleston, RN, Special Investigator

Finding: Inconclusive

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 resident was abused when an unknown male sexually assaulted the resident at the facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident indicated an unwanted sexual encounter occurred while she resided at the facility but did not provide further information.

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

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder, bipolar, and opioid and stimulant dependence. The resident's service

plan included assistance with medication management, reminders, behavior management and interventions, and orientation related to confusion and delusions. The resident's assessment indicated the resident refused medications at times and obtained medications and drugs that were not prescribed to her for usage. The assessment indicated the resident was sexually active and able to give consent for sexual activity. The assessment also indicated the resident occasionally needed redirection when mildly disoriented to person, place, or time.

Review of the resident' record during the time in question indicated the resident took an outing into the community and chose not to return to the facility the same day as expected. Because the overnight stay was not expected, staff did not set up the resident medications. When the resident returned to the facility, the resident stated she wanted to be evaluated and pointed to her genitals. The record indicated the resident initially denied being sexually assaulted, however, the day after returning the resident made comments to a nurse that suggested the resident may have been sexually assaulted. Because the resident initially denied being sexually assaulted until the following day, facility staff did not arrange for the resident to have a sexual assault examination.

Review of provider progress notes during the time in question indicated six days prior to the alleged assault, the resident was seen by her provider and prescribed a steroid cream for irritation to the resident's vaginal area. Facility staff arranged for a provider visit seven days after the alleged assault and the resident was diagnosed with a vaginal yeast infection and prescribed anti-fungal medications. The provider note did not mention the possibility of the resident being sexually assaulted.

During investigative interviews, multiple staff members stated the resident alluded to having been sexually assaulted but refused to provide further information regarding the incident.

During an interview, the resident stated she was sexually assaulted while residing at the facility but did not want to discuss further or provide additional details.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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; Stop here if it is not a restraints issue or sexual abuse.
(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: Yes
Family/Responsible Party interviewed: Not applicable.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
Facility encouraged the resident to seek medical attention and conducted an internal review of the allegation.

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
	31417	A. BUILDING: _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORE ASSISTED LIVING	202 EAST NORTH STREET ELMORE, MN 56027

(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 16, 2023, the Minnesota Department of Health initiated an investigation of complaint HL314174683C/HL314172806M. No correction orders are issued.	0 000		