

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL324375681M  
**Compliance #:** HL324377944C

**Date Concluded:** November 8, 2024

**Name, Address, and County of Licensee**

**Investigated:**

Oak Terrace Le Seur  
811 South 4th Street  
Le Seur, MN  
Le Seur County

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

**Evaluator's Name:** Lena Gangestad, RN  
Special Investigator

**Reconsideration Analyst:** Jacci Nickell

**Finding:** Substantiated, individual responsibility, AP1. Inconclusive, individual responsibility AP2.

**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 alleged perpetrators (AP #1 and AP #2) abused the resident when AP #1 and AP #2 were in the bathroom to assist the resident after he used the toilet. AP #2 saw AP #1 begin recording a video of the resident while his pants were down and swinging his T-shirt at them. AP #2 asked AP #1 To send her the video since it was funny.

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined abuse was substantiated. AP#1 was found and AP#2 were responsible for the maltreatment. AP#1 recorded the resident and shared the video with AP#2 via Snapchat.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted the resident's family member. The

investigation included review of resident's records, the AP#1 and AP#2's personnel record, facility's policies and procedures, incident reports. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia. The resident's service plan included assistance with all activities of daily living which included hygiene, dressing, toileting, and medications.

One afternoon, AP#1 and AP#2 assisted the resident in using the bathroom. The resident became agitated and started throwing punches at the staff. While AP#2 tried to calm the resident, AP#1 took out her phone and recorded the resident as he swung his shirt toward them. The video screen shot showed the resident sitting on the toilet, half-naked with his pants down, holding his t-shirt with one hand. After the incident, AP#1 shared the video via Snapchat, and AP#2 asked her to send the video to her phone.

During an interview, AP#1 stated she had worked at the facility for around six months. She said she was with AP#2 in the bathroom to assist the resident when the resident became aggressive and started swinging his shirt around. While AP#2 was trying to calm him down, she said she stepped back and began recording a video of him. She claimed her intention was to show others how bad his behavior was. She stated that she and AP#2 discussed the incident but did not laugh about it. She said she sent the video to AP#2 but deleted immediately after another unlicensed caregiver saw it. She stated she did not send it to anyone else. She said the incident happened on Friday, and she was fired on Monday. She explained that the reason she did not tell anyone was because it was the weekend, and no manager was in the building.

During an interview, AP#2 stated that she and AP#1 went to the bathroom to help the resident get changed. The resident became agitated and started throwing punches at both her and AP#1. She said she was trying to calm him down while AP#1 recorded a video of him. She stated the video did not show any of his private areas. She said AP#1 shared the video with her on Snapchat, although she had not asked for it. She explained that on Snapchat, a person can choose who to send a picture or video to and can snap back and forth. AP#1 only sent that video to her, and it disappeared after being viewed. She stated while it is possible to screenshot a snap, she said she did not do that. She said that AP#1 should not have recorded the video but explained that she had no one to report it to since there was no nurse in the building over the weekend. She acknowledged she should have reported the incident immediately but did not. She said another unlicensed caregiver made the report and she and AP#1 were let go after the incident.

During an interview, an unlicensed caregiver stated that she saw AP#1 and AP#2 at the nurses' station, laughing while on their phones. She said she heard AP#2 ask AP#1 to send her the video because it was so funny. Then, AP#1 asked the unlicensed caregiver if she wanted to see the video of the resident and showed it to her. She said AP#1 showed her a video of the resident sitting on the toilet, half-naked with his pants down, holding his t-shirt in one hand and trying

to hit AP#1 and AP#2 with it. She said she then emailed the facility manager to report what happened and also sent a picture of AP#1 showing her the video to the director.

During an interview, a manager stated she received a report from the unlicensed caregiver about AP#1 and AP#2. She said the complaint was about AP#1 recording a video of the resident throwing his shirt in the air. She began the investigation and spoke with AP#2, while another manager spoke with AP#1. She said they fired AP#1 immediately, and since AP#2 changed her story multiple times and was not honest, they decided to let her go as well, even though she was not the one who recorded the resident. The manager stated there was also a witness who reported that she heard AP#2 asked AP#1 to send her the video. The manager also stated that she notified the police department and the resident's family about the incident.

In conclusion, the Minnesota Department of Health determined abuse was substantiated for AP1 and inconclusive for AP2.

**Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.**

"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

**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; or
- (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 unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

(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, unable to be interviewed due to dementia.

**Family/Responsible Party interviewed:** Yes.

**Alleged Perpetrator interviewed:** Yes.

**Action taken by facility:**

The facility reported to the police department, started the investigation. AP#1 and AP#2 are no longer employed by the facility.

**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.

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

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

Le Seur County Attorney

Le Seur City Attorney

Le Seur Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32437</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/08/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>OAK TERRACE OF LE SUEUR LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>811 SOUTH 4TH STREET LE SUEUR, MN 56058</b>
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(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 October 8, 2024, the Minnesota Department of Health initiated an investigation of complaint HL324375681M/HL324377944C. The following correction order is issued, tag identification 2360.	0 000		
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: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.  Findings include:  The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and two individuals were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_