Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL357052922M
Compliance #: HL357052719C

Date Concluded: June 20, 2024

Name, Address, and County of Licensee Investigated:
Jabez Customized Living Services
8350 Pierce Street NE
Spring Lake Park, MN 55432
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, 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):
A facility staff member/alleged perpetrator (AP) abused the resident when the AP and the resident engaged in a sexual relationship resulting in the resident being hospitalized with suicidal thoughts.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The investigation found there was insufficient evidence to determine if abuse occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement, the resident's case worker and therapist. The investigation included review of the resident's records, hospital records, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, a law enforcement report, and related facility policies and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder, anxiety, and suicidal ideation. The resident's service plan included assistance with mental health management and medication management. The resident's assessment indicated the resident displayed short term memory loss and had a history of delusions and psychosis.

Complaint documents indicated the resident reported she had a sexual relationship last year with a staff member/alleged perpetrator (AP) which included the AP sniffing the resident's underwear and performing oral sex on the resident. The resident became emotionally upset after reporting the incident, resulting in suicidal ideations and hospitalization.

Hospital records indicated the resident reported thoughts about cutting her wrists. The resident informed hospital staff that facility management did not like her and she was trying to move out of the facility. The resident did not report the sexual relationship with the AP to hospital staff and the resident was discharged back to the facility.

A police report indicated the resident stated that a sexual encounter occurred with the AP but the resident could not recall the details of the incident. The resident informed police she did not want to pursue criminal charges because she felt better after a medication adjustment.

The resident declined to be interviewed.

During an interview, the resident's therapist stated the resident reported that she had sexual contact with the AP, but did not elaborate on the details. The resident reported that she was having suicidal ideations because she didn't feel safe at the facility and wanted to get out, so the therapist suggested for the resident to be seen in the hospital. The resident called 911 and was sent to the emergency room. The resident was not admitted to the hospital and discharged back to the facility. The therapist stated the resident had not expressed any safety concerns since the hospital visit.

During an interview, facility management stated they were notified by police of the resident and AP's alleged sexual relationship. The AP was immediately suspended, and an investigation was conducted. The AP denied the allegation. The resident told facility management the concern was none of their business and that the AP and the resident had sex one to two years ago in the facility living room. The resident refused to tell facility management any further details and that she didn't have to tell them anything. The resident did not report this allegation to the facility staff, hospital staff, or to her psychiatrist. The facility provided education to staff after the incident and installed additional cameras.

During an interview, the AP denied sniffing the resident's underwear, denied performing oral sex on the resident, and denied having a sexual relationship with the resident.

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;
(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: No. The resident declined to interview.
Family/Responsible Party interviewed: No. Family was not available for interview.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility suspended the AP, completed an investigation, and completed education with facility staff.

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
	35705	A. BUILDING: _____ B. WING _____	C 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JABEZ CUSTOMIZED LIVING SRVCS	8350 PIERCE STREET NE SPRING LAKE PARK, MN 55432

(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 April 23, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL357052719C/#HL357052922M. No correction orders are issued.	0 000		