

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL360298682M
Compliance #: HL360296282C

Date Concluded: March 24, 2025

Name, Address, and County of Licensee

Investigated:

St. John Home Care LLC
17515 30th Avenue North
Plymouth, MN 55447
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Willette Shafer, RN
Special Investigator

Finding: Substantiated, facility and individual 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 alleged perpetrator (AP) neglected resident-1 when the AP failed to supervise resident-1 and a male visitor at the facility sexually assaulted resident-1.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility (AP-2) and the AP (AP-1) were responsible for the maltreatment. Resident-1's care plan indicated resident-1 was not allowed to be alone with men, however AP-1 allowed the male visitor, a reported Lyft driver who drove resident-2 home, and resident-1 to be alone in resident-1's bedroom with the door closed. Resident-1 reported the male visitor sexually assaulted her and was bleeding from her vagina and anus.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator contacted law enforcement and resident-1's guardian. The investigation included review of the resident records, facility internal investigation,

personnel files, staff schedules, law enforcement report, video footage from the day of the incident, and related facility policy and procedures. Also, the investigator toured the facility.

The resident resided in an assisted living facility. The resident's diagnoses included mood disorder, sexual disorder, post-traumatic stress disorder. The resident's service plan included assistance with medication management, meals, personal laundry, housekeeping, shopping, managing behaviors, and orientation.

A law enforcement report indicated resident-1 alleged she was sexually assaulted by a Lyft driver (visitor) who was brought to the house by resident-2. Resident-2 received a ride home from the visitor, when he came in the facility to charge his vape. The visitor charged his vape pen in resident-2's bedroom while resident-1 and another resident hung out in the bedroom with him. The visitor left briefly and returned with food and cigarettes. The visitor then went to resident-1's bedroom where they proceeded to watch a movie. During the movie, the visitor began to grope and kiss resident-1. Resident-1 and the visitor had vaginal and anal sexual intercourse. Resident-1 told the visitor to stop during anal penetration as it caused pain. The visitor stopped. When resident-1 went to the bathroom she was bleeding vaginally and anally. The visitor was at the facility for roughly an hour and a half. The staff member notified AP-2, who is also the owner, who then contacted the police. Resident-1 was taken to the hospital for a sexual assault exam.

During an interview, resident-1 said resident-2 called her and told her she was bringing a good-looking man home for her. The visitor came in to charge his vape and then left to get food for her and AP-1. When the visitor returned, resident-2 brought him to resident-1's bedroom. She was not supposed to have anyone in her room, but the staff allowed him in her bedroom. While resident-1 and the visitor watched a movie, the visitor groped resident-1, took his pants and her clothes off and "shoved" himself in her. Resident-1 said she froze and could not scream as she was shocked. She said he penetrated her vaginally and anally with his penis. After the visitor stopped, she went to the bathroom and saw she was bleeding from her vagina and anus. She said AP-1 allowed the man in her room although she was not to have anyone in her room. She said her door was open initially but when AP-1 checked on her, AP-1 closed her door. Resident-1's door locks automatically when the door is closed. Resident-1 told AP-1 what happened, and AP-1 was afraid she would be in trouble when AP-2 found out about the incident. Resident-1 had never met the visitor prior to the sexual assault. Resident-1 said AP-1 knew she was not allowed visitors in her room, but resident-2 told AP-1 resident-1 was allowed to have visitors in her room, so AP-1 allowed it.

During an interview, resident-1's guardian said resident-2 brought a visitor to the facility who had given her a ride home. AP-1 was a newly hired employee and asked resident-2 if resident-1 was allowed to have people in her room. Resident-1 was not allowed to have anyone in her room. She was also not allowed to have a phone as she had inappropriate sexual behaviors. The guardian said AP-1 should have known resident-1 was not allowed to have men in her bedroom.

During an interview, AP-1 said she worked the evening of the incident. Resident-2 brought a visitor to the facility who had given her a ride home. She said the visitor left briefly to get them food. When the visitor left, resident-2 helped clean resident-1's room and sprayed perfume to make it smell nice. When the visitor returned, he went into resident-1's room with resident-1. She was concerned resident-1 had a man in her room and thought about calling AP-2, but the residents told her resident-1 was allowed to have visitors. She was originally hired for a different facility AP-2 owned but recently transferred to this location. She had worked in this location for one month before the incident. She received orientation to the residents at the previous facility but never received orientation on how to provide care to residents at this location. She checked on resident-1 and the visitor once while they were in the bedroom. She never checked on them again as she was making something in the oven.

Per resident-1's service delivery record, AP-1 documented her initials at 4:00 p.m., on resident-1 "cannot to be alone with any other resident or male".

During an interview, AP-2 said resident-1 was not allowed to have men in her room as she had inappropriate sexual behaviors. AP-2 said AP-1 was aware men were not allowed in resident-1's room. AP-2 said when AP-1 called her she told her she did not know resident-1 was not allowed to have visitors in her room. AP-1 told her residents at the facility said resident-1 was allowed to have visitors, so she allowed it. AP-2 said AP-1 should have called and clarified if she was confused. AP-2 said AP-1 had called her in the past to ask if other residents were allowed to have visitors. AP-1 worked at a different facility owned by AP-2 before the incident. AP-1 was terminated from the prior facility for disrespectful interactions with the residents. A recent sexual assault incident at this location required a staff member be moved to a different location so AP-2 hired AP-1 again to work at this location.

Video surveillance of the facility showed the visitor and resident-1 alone in resident's room for over an hour without AP-1 observing them.

AP-2 failed to provide a completed background check for AP-1. No record of a completed background check was found from review of the background study database. Per the staff schedule, AP-1 worked alone every day since she was hired at this facility which demonstrated the facility failed to provide resident orientation to AP-1 prior to providing direct care.

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

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.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) AP-1 followed an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility failed to provide proper training and/or supervision of staff.

The facility and AP-2 failed to provide adequate staffing levels.

AP-1 failed to follow the facility directive and/or policies and procedures.

AP-2 had the authority to direct and implement operational regulatory requirements or make operational changes.

(3) The facility, AP-1 and AP-2 failed to follow professional standards and/or exercise professional judgement.

AP-1 failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: Yes.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility completed an internal investigation. The AP no longer worked at the facility.

Action taken by the Minnesota Department of Health:

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

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

Hennepin County Attorney

Plymouth City Attorney

Plymouth Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/23/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ST JOHN HOME CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 17515 30TH AVENUE NORTH PLYMOUTH, MN 55447
--	--

(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>HL360298462M/HL360295362C HL360298683M/HL360296283C HL360298682M/HL360296282C</p> <p>On January 23, 2025, 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 3 residents receiving services under the provider's Assisted Living license.</p> <p>The following correction order is issued for HL360298462M/HL360295362C, HL360298682M/HL360296282C tag identification 2360.</p> <p>There are no correction orders issued for HL360298683M/HL360296283C.</p>	0 000	<p>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 Facilities. 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 evaluators' findings is the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>	

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/23/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ST JOHN HOME CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 17515 30TH AVENUE NORTH PLYMOUTH, MN 55447
--	--

(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
02360	Continued From page 1	02360		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure two of three resident(s) reviewed (R1, R2) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and an individual person were responsible for the maltreatment of R1 and R2, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p>	02360		