Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL360298683M
Compliance #: HL360296283C

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: 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 alleged perpetrator (AP) abused the resident when the AP rubbed the resident's leg and made inappropriate sexual comments to her after the AP fixed a window in the resident's bedroom.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The resident was unsure of the date or timeframe of the incident. Also, she was unsure if the AP was someone related to the owner or a maintenance worker. Law enforcement investigated the allegation and determined no charges would be filed. The resident declined an interview request.

The investigator conducted interviews with facility staff members, including administrative staff members. The investigator contacted law enforcement and attempted to contact the resident's case worker. The investigation included review of the resident's record, personnel files, staff

schedules, law enforcement report, and related facility policy and procedures. Also, the investigator toured the facility and observed interactions between residents and staff.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder bipolar type and borderline personality disorder. The resident's service plan included assistance with medication administration, meals, housekeeping, shopping, and behavior management. The resident's assessment indicated the resident refused to follow facility rules including going into other resident's bedrooms, giving other resident's things they are not allowed to have, threatening physical harm to others, and making false allegations.

The resident's progress notes indicated several incidents where she made false allegations or lied to staff. One incident where she removed the facility informational bulletin board and denied she took it. Video surveillance showed the resident took the bulletin board off the wall and hid it.

Resident's assessment indicated she refused to follow facility rules including going into other resident's bedrooms, giving other resident's items they should not have, and using drugs. She was verbally and physically abusive towards staff and peers, fabricated stories, and refused to follow her care plan including medical advice.

A law enforcement report indicated the resident reported the incident to her case manager and a county crisis support member. The resident told her case manager she would report the incident to the law enforcement, but she never reported it. The resident told her case manager, the AP fixed the window in her bedroom while she laid in bed. The resident reported the AP touched her leg and said, "if the window doesn't keep you warm, I will." When law enforcement met with the resident about a different case, she never mentioned this incident, although she had previously reported it to her case manager. The resident was unable to recall the date of the incident, she was unsure who the AP was. Possibly a maintenance worker or someone else. A maintenance worker fixed the window around the date of the allegation. He provided services at the facility in the past and he was accompanied by a staff member while inspecting the window in the resident's bedroom. The inspection took seconds, and he fixed the window from the outside of the facility. The staff member who worked the day the window was repaired verified she escorted the maintenance worker while he was in the resident's bedroom. The staff member said the maintenance worker never spoke to or touched the resident. The resident was informed the police would not file charges.

During an interview, the AP said the owner asked him to close the resident's window as it was ajar, and a draft was coming through the window. The AP went to the facility, closed the window and applied duct tape to keep the draft out. The AP said the staff member who worked came to the resident's room with him and helped him close the window. He was unable to recall the date or staff member who assisted him. He said the resident was lying in bed completely covered while he closed the window. He said he never touched her or made any inappropriate comments to her.

During an interview, the owner said she asked the AP to go to the facility and close the resident's window. The owner was unable to recall the date or the staff member who worked that day. She said the resident never reported anything to her. She said she first heard about the incident from the police. It is unclear who the resident made these allegations against as the AP later fixed the resident's window. The AP fixed the window from outside the facility. The owner said the resident had a history of making false allegations.

In conclusion, the Minnesota Department of Health determined abuse 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.

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. She never returned requests for an interview.
Family/Responsible Party interviewed: No, family declined.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility spoke to the police about the incident. The facility implemented interventions to prevent future incidents.

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
	36029	A. BUILDING: _____ B. WING _____	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	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	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER 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: HL360298462M/HL360295362C HL360298683M/HL360296283C HL360298682M/HL360296282C 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. The following correction order is issued for HL360298462M/HL360295362C, HL360298682M/HL360296282C tag identification 2360. There are no correction orders issued for HL360298683M/HL360296283C.	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 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. 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 SUBDIVISION 1-3.	

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02360	Continued From page 1	02360		
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 two of three resident(s) reviewed (R1, R2) was free from maltreatment. Findings include: 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.	02360		