Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: H5222117M

Date Concluded: June 7, 2021

Name, Address, and County of Licensed Investigation:
The Estates at Chateau LLC
2106 2nd Ave S.
Minneapolis, MN 55404
Hennepin County

Facility Type: Nursing Home

Investigator's Name: Yolanda Dawson, RN
Special Investigator

Finding: Not Substantiated

Nature of Visit: 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.

Allegation(s): It is alleged that the resident was sexually abused when the alleged perpetrator (AP) began a sexual relationship with the resident while he was a resident receiving care in the facility in which she was employed.

Investigative Findings and Conclusion:
Abuse was not substantiated. The AP and the resident had a sexual relationship prior to the resident's admission to the facility. While it was against facility policy for the AP to have a sexual relationship with a resident, it did not meet the definition of abuse because of the pre-existing relationship.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator reviewed the internal investigation documents, personnel files, and policies and procedures.

The resident was diagnosed with unspecified fracture of left lower extremity post incision and drainage of cellulitis at nail site. The resident received services from the skilled nursing facility

for medication management, IV medication administration, wound care, vital signs, behavior monitoring, bathing, grooming, and dressing assistance as needed, and meal preparation. The resident was independent and able to come and go from the facility at will.

During an internal investigation interview, the AP reported she knew the resident before he was admitted to the facility. The AP reported she did have a sexual relationship with the resident while he was a resident.

During an interview, a director of nursing (DON) stated the resident was discharged from the facility in December 2020. In April of 2021, the resident contacted an administrator via email to inform them that he and the AP had a sexual relationship while he was a resident. The resident provided a photograph of him and the AP in bed. The resident reported he knew it was wrong and felt bad about it. The DON stated the AP reported she knew it was wrong and wanted to come forward but was afraid.

During an interview, the AP stated in 2014-2015 she and the resident were in a relationship for approximately three months. The AP stated that in August 2020 the resident entered the facility as a resident receiving care and they became reacquainted. The AP stated that somewhere between August 2020 and December 2020, she rekindled a sexual relationship with the resident. The AP stated the sexual relationship occurred for one week and took place at her home. The AP stated she was trained on the safety of vulnerable adults and aware of resident-employee boundaries, but thought the relationship was appropriate because she had a previous history with the resident.

In conclusion, sexual 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;
(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.
…
(g) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:
(1) a person, including a facility staff person, when a consensual sexual personal relationship existed prior to the caregiving relationship.

Vulnerable Adult interviewed: No, attempted but did not reach.
Family/Responsible Party interviewed: No, VA was independent of family.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Internal investigation conducted. AP is no longer employed by the facility. All staff reeducated on client employee boundaries.

Action taken by the Minnesota Department of Health:
The facility was issued a federal deficiency and/or a state correction order for noncompliance with licensing requirements. For a copy of the Statement of Deficiencies, please call 651-201-4890.

cc:
The Office of Ombudsman for Long-Term Care
Hennepin County Attorney
Minneapolis City Attorney
Minneapolis Police Department
Minnesota Board of Examiners for Nursing Home Administrators