Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #:H53121301M, H5312061M

Date Concluded: October 4, 2022

Name, Address, and County of Licensee Investigated:
Flagstone
12500 Castlemoor Drive
Eden Prairie, MN 55344
Hennepin County

Facility Type: Nursing Home

Evaluator's Name: Angela Vatalaro, RN
Special Investigator
Brandon Martfeld, RN
Special Investigator

Finding: Substantiated, individual responsibility

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.

Initial Investigation Allegation(s):
The alleged perpetrator (AP), a staff member, sexually abused resident 1 when he fondled resident 1's breasts, nipples, and made sexual comments. It is also alleged the AP sexually abused resident 2 when he fondled resident 2's breasts.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. There was a pattern of behavior to support preponderance of evidence the AP fondled residents 1's breasts, nipples, made repeated sexual comments towards resident 1, and fondled resident 2's breasts.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and resident 2's family. The AP declined to interview. The investigator contacted law enforcement and reviewed law enforcement reports. The investigation included review of resident 1 and resident 2's medical records, Minnesota Department of Health (MDH) survey notes, internal investigation notes, the AP's personnel file, and facility policies related to maltreatment.

Resident 1 resided in a nursing home. Resident 1's diagnoses included cardiomyopathy (disease of the heart muscle). Resident 1's care plan indicated resident 1 required assistance with dressing, bathing, grooming, hygiene, and used a wheelchair. Resident 1's Brief Interview of Mental Status (BIMS) test indicated resident 1 was cognitively intact.

Resident 2 resided in a nursing home. Resident 2's diagnoses included dementia. Resident 2's care plan indicated resident 2 required assistance with dressing, grooming, toileting, transfers, and used a wheelchair. Residents 2's BIMS test indicated resident 2 had severe cognitive impairment.

The facility's internal investigation indicated one day it was reported the AP fondled resident 1's breasts, nipples, and told resident 1 she had breasts of an 18-year-old and asked how she did it. During the investigation, resident 2 also reported the AP inappropriately touched her breasts.

Resident 1's facility internal investigation interviews indicated the AP had a fixation on her breasts, touched her breasts more than once, and made comments she had breasts of an 18-year-old. Resident 1 stated the evening the AP touched her nipples, resident 1 had took off her own bra and put her nightgown on herself. She said the AP helped her to bed. The AP touched her breasts under her nightgown from the side up by her neck area and caressed her breasts. The AP went from one breast to the other, and resident 1 said she got uncomfortable and mad when the AP touched her nipples. Resident 1 said the AP pushed on her nipples with his fingers, touched them, and asked "doesn't that feel good?" Resident 1 said she slapped the AP away, told the AP to stop it, and to not touch her again. She said the AP touched her breasts before, but this evening was the first time he touched her nipples like that.

MDH survey notes indicated another resident stated she heard resident 1 yell at the AP and say stop it.

Resident 1's psychology notes indicated resident 1 had trouble sleeping the first three nights after the incident along with nightmares.

The law enforcement report indicated resident 1 stated the AP touched her breasts multiple times during evening cares. The AP put his ungloved hand under her night gown and touched her bare breasts, touched her nipples, and asked her if it felt good. Resident 1 said this could not have happened as part of routine care because the AP would put his hands in her nightgown and went in at an angle. Resident 1 also stated the AP moved her nightgown to get at her nipples.

Resident 2's facility's internal investigation interview indicated resident 2, identified the AP (she had a name she called the AP routinely that was not his legal name). Resident 2 stated the AP always tried to feel her up, and touched her breasts. Resident 2 stated the AP was not washing her breasts or putting on lotion. Resident 2 stated she was not sure why the AP touched her breasts. Resident 2 said she had a nightgown on, the AP touched her breasts on top of the night gown, and this happened when she was in bed.

The law enforcement report indicated resident 2 stated she did not like the man (same name the AP confirmed resident 2 identified him by) touching her in a way that made her uncomfortable.

The AP's facility internal investigation interviews indicated the AP touched resident 1's nipples during evening cares as part of his job, and his hand brushed them. The AP stated he did heavier touch of residents 1's breasts when he removed residents 1 bra (made gestures to show removal of bra from pulling front of sports bra out and overhead). When asked to explain how touching resident 1's nipples were part of care, the AP stated he adjusted the cups in resident 1's bra and resident 1's nipples got accidently touched during that. The AP stated resident 1 wore a sports bra. The AP said he did tell resident 1 she had nice breasts and they looked like an 18-year-old's breasts. The AP stated he made comments more than once to resident 1 about her breasts. The AP stated resident 1 did not say anything in response to the comments or tell him to stop during cares. The AP stated there were times resident 1 removed her own bra and put her nightgown on herself. When asked if resident 1 had put her own nightgown on or took off her own bra during the evening of the reported incident, the AP said he did not remember. The AP stated resident 2 called him by a different name and confirmed the name resident 2 called him by. The AP stated resident 2 did not wear a bra, and he touched residents 2 breasts when he got her dressed in bed. The AP said he touched resident 2's breasts when he put on resident 2 's nightgown or a shirt. When asked why he touched residents 2's breasts, the AP stated sometimes but not all the time his hands go to the breasts when putting on resident 2's shirt.

During an interview, leadership staff 1 stated they received a report the AP fondled resident 1's breasts, nipples, and told resident 1 her "titties look like titties of an 18-year-old." Leadership

staff spoke to the AP who stated he made repeated comments to resident 1 about her breasts, told her she had nice breasts, and did state he told resident 1 she had breasts of an 18-year-old. The AP stated he touched resident 1's breasts and nipples as part of care delivery. The AP stated resident 2 associated him by a different name and confirmed the name resident 2 identified him by. It was the same name resident 2 used during her interview. The AP stated resident 2 did not wear a bra, and stated he touched resident 2's breasts when he assisted with dressing.

During an interview, nurse 1 stated the AP stated he touched the residents' breasts and nipples as part of care delivery. Resident 1 stated the AP touched her breasts in circular, repeated, and a caressing motion. The nurse stated resident 1 wore a sports bra and the sports bra was tight. The nurse stated to assist resident 1 with putting on or removing a sports bra it would be more of a brush type touch not a repeated touch. The nurse stated resident 2 did not wear a bra and received care which included washing under the breasts with dressing. The nurse stated staff trained to lift the breasts up using the knuckles or back of hand to wash under breasts. The nurse said there was not a care related need to touch resident 2 breasts on top of a nightgown.

During an interview, nurse 2 stated the facility conducted two interviews with resident 1, on two separate days. Nurse 2 stated resident 1's report of what occurred with the AP remained consistent during both interviews.

The AP declined to interview.

In conclusion, the Minnesota Department of Health determined abuse 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.

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:
(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;
(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.

Vulnerable Adult interviewed: No, attempted resident 1 but did not reach, resident 2 unable due to cognition.
Family/Responsible Party interviewed: Yes, except no family member reached for resident 1.

Alleged Perpetrator interviewed: No, declined to interview.

Action taken by facility:
The facility placed the AP on administrative leave pending internal investigation and contacted law enforcement. The AP is no longer employed by 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.

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
Eden Prairie City Attorney
Eden Prairie Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00973	A. BUILDING: _____ B. WING _____	C 10/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLAGSTONE	12500 CASTLEMOOR DRIVE EDEN PRAIRIE, MN 55344

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H53121301M, #H5312061M in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	2 000		

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2 000	Continued From page 1 #H53121301M, H5312061M tag identification 1850. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.	21850		

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21850	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure two of two residents reviewed (R1, R2) were free from maltreatment. R1 and R2 were abused. On October 4, 2022, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	21850	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	