Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201871160M
Compliance #: HL201871864C

Date Concluded: August 17, 2022

Name, Address, and County of Licensee Investigated:
Brainerd Carefree Living
2723 Oak Street
Brainerd, MN 56401
Crow Wing County

Facility Type: Assisted Living Facility (ALF)

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

Initial Investigation Allegation(s):
The facility neglected resident 1 and resident 2 when resident 2 had resident 1 perform oral sex.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although resident 1 made allegations resident 2 requested oral sex from resident 1, facility leadership reviewed security camera footage which revealed resident 2 did not enter resident 1's room the evening of the alleged incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. Investigator made multiple attempts to interview resident 1 and resident 2 but was not successful. The investigator contacted law enforcement and reviewed law enforcement report. The investigation included review of resident 1 and resident

2’s medical records, policies and procedures related to vulnerable adults and safety checks. Also, the investigators observed the area both residents resided in, and interactions between resident 1 and resident 2.

Resident 1 resided in an assisted living facility. Resident 1’s diagnoses included mental health conditions. Resident 1’s service plan included assistance with bathing, medication management, housekeeping, laundry, and safety checks. Resident 1’s assessment indicated resident 1 was alert and orientated. The same assessment indicated resident 1 was vulnerable to abuse from others due to cognitive deficits, could be taken advantage of by strangers and has not always used good judgement.

Resident 2 resided in an assisted living facility. Resident 2’s diagnoses included type 2 diabetes, absence of right and left leg above knee. Resident 2’s service plan included assistance with bathing, toileting, medication management, housekeeping, laundry, and safety checks. Resident 2’s assessment indicated resident 2 was alert and orientated. The same assessment indicated resident 2 had no history of abuse to others.

Resident 1’s progress notes indicated resident 1 reported resident 2 came into the resident 1’s room between 4:00 p.m. and 4:30 p.m. Resident 1 reported resident 2 wheeled himself to the side of her bed, removed his penis, and requested oral sex. Resident 1 stated she declined once, but then performed oral sex after resident 2 requested a second time. Resident 1 reported resident 2 attempted to get into her bed, was unable, and resident 1 assisted resident 2 back into his wheelchair. Resident 2 left resident 1’s room, went back to his room, returned a short time later and gave resident 1 $100. The next day, facility leadership reviewed security camera footage. The camera footage reviewed from 3:00 p.m. through 7:30 p.m. revealed resident 2 coming to the doorway of resident 1’s room at 7:24 p.m. Camera footage revealed resident 2 never crossed the doorway threshold of resident 1’s room with his wheelchair. Resident 2 was in resident 1’s doorway for five minutes. Five minutes later, resident 2 returned to his room and did not return to resident 1’s room.

A law enforcement report indicated facility leadership reviewed the security camera footage between the hours of 3:00 p.m. through 7:00 p.m. The security camera footage revealed resident 2 was in resident 1’s doorway for approximately five minutes and left.

During an interview, an unlicensed staff member stated both resident 1 and resident 2 were alert and orientated. The unlicensed staff member stated both resident 1 and resident 2 had call pendants, knew how to use them, and had alerted staff when they needed assistance. He stated he had not seen resident 2 behind closed doors of resident 1’s room and had only witnessed resident 2 at the doorway of resident 1’s room conversing.

During an interview, facility leadership stated after learning of the allegation, she reviewed the security camera footage. Resident 1 stated the incident occurred with resident 2 after dinner. Facility leadership stated she watched the camera footage, seen resident 2 come to resident 1’s

room after dinner. Resident 2 never crossed the doorway into resident 1's room. Resident 2 was in the doorway for approximately five minutes, and then went back to his room, and never returned to resident 1's room that evening. Facility leadership stated leadership spoke to resident 1 and resident 2 separately about avoiding each other and ensured both residents felt safe at the facility.

During an interview, nurse 1 stated the facility investigated the alleged incident. Nurse 1 stated camera footage did not reveal resident 2 entered resident 1's room as resident 1 reported. Nurse 1 stated both resident 1 and resident 2 ate meals together prior to the alleged incident. After hearing of the alleged incident, the facility separated both residents to ensure they ate at separate tables. Nurse 1 stated resident 1 and resident 2 rooms were on the same floor at the facility. Nurse 1 stated both residents were spoken to separately about avoiding each other, refraining from any further relationship, and both residents were offered to move to a different room on different floors. Neither resident wanted to move and both residents continued to stay on the same floor. Both residents stated they felt safe at the facility. Nurse 1 stated resident 1 and resident 2 were both their own decision makers and directed their own care. Nurse 1 stated at the time of the alleged incident, resident 1 had multiple medications adjusted for her mental health. Resident 1 made comments about increased anxiety and heard voices in her head. Nurse 1 stated she updated resident 1's provider and resident 1's medications adjusted. After resident 1's medications adjusted, resident 1's mental health improved. Nurse 1 stated nursing monitored resident 1's and resident 2's behaviors for several weeks and no concerns were reported. Nurse 1 also stated there had been no further incidents involving resident 1 and resident 2.

In conclusion, the Minnesota Department of Health determined neglect 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.

Vulnerable Adult interviewed: No, attempted resident 1 and resident 2, but did not reach.
Family/Responsible Party interviewed: No, resident 1 and resident 2 were responsible for self.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Once the facility learned of the incident, staff reviewed security camera footage. Resident 1 and resident 2 were separated to different dining tables and both were offered a different room on a different floor. Nursing monitored both residents after the alleged incident.

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
	20187	A. BUILDING: _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAINERD CAREFREE LIVING LLC	2723 OAK STREET BRAINERD, MN 56401

(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 Initial comments On August 9, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL201871864C/#HL201871160M. No correction orders are issued.	0 000		