Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL204621860M
Compliance #: HL204629628C

Date Concluded: March 7, 2024

Name, Address, and County of Licensee Investigated:
Oak Meadows Senior Living
8131 4th Street North
Oakdale, MN 55128
Washington County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, 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), facility staff, abused a resident when the AP inappropriately touched the resident's intimate parts on several occasions.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP established an emotional connection with the resident which led to inappropriate sexual contact. The resident sustained psychological injury (including increased anxiety, feelings of panic, self-doubt, and social isolation) which required ongoing support from a mental health professional.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family, a mental health professional, and law enforcement. The investigation included review of the resident records,

facility internal investigation, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed staff interactions with residents.

The resident lived in an assisted living facility. The resident's diagnoses included depression, anxiety, and dementia. The resident's service plan included assistance with medication administration. The resident's assessment indicated she independently completed bathing, dining, dressing, grooming, ambulation, bed mobility, transfers, and toileting.

A facility internal investigation indicated one day the resident informed a family member the AP touched her intimately on several occasions while the AP was in the resident's apartment administering her medications. The resident spoke of instances of hugging, touching in a too familiar way, touching the resident's breast, and touching the resident's vagina. As the investigation continued, the resident tried to take back the statements for fear of hurting the AP, but ultimately provided consistent information to the family, facility, and law enforcement.

During the facility investigation the resident stated the AP always made a point to say good night to her before he left, and once kissed her. The resident indicated his moustache was soft. The resident indicated the AP suggested the resident buy some wine once when she was upset, and she inferred they would share it together.

During an interview, an administrative staff stated she interviewed the AP after the report. The AP told the administrative staff he would not deny any accusations that occurred in the previous three weeks, as the AP had been having a difficult time. The administrative staff stated the AP took responsibility for inappropriate touching the resident and stated he felt his actions ruined his career.

During investigative interviews, family members stated one day the resident said she wanted to talk about something and appeared upset. The family members stated the resident talked about her initial relationship with the AP and things they had in common. The family members stated the resident then relayed several instances of intimate contact by the AP in the previous two months, as well as gifting the AP some money. The family members indicated the resident had increased emotional difficulties after hearing the AP no longer worked at the facility.

During an interview, a mental health professional stated the resident showed increased levels of anxiety, social isolation, and questioned her own decision-making ability after the incidents.

The law enforcement report indicated the case was forwarded to the County Attorney for charges of Criminal Sexual Contact in the fourth degree.

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:
(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 (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.

Vulnerable Adult interviewed: No, at request of the family.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Declined to interview.

Action taken by facility:
The facility investigated the allegations, reached out to police, and terminated the AP. The facility provided re-education to all staff on maltreatment of vulnerable adults and boundaries. The facility updated the resident's services to include only female caregivers.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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
Washington County Attorney
Oakdale City Attorney
Oakdale Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20462	A. BUILDING: _____ B. WING _____	C 02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK MEADOWS	8131 4TH STREET NORTH OAKDALE, MN 55128

(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 order is 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: #HL204629628C/#HL204621860M On February 21, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 60 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL204629628C/#HL204621860M, tag identification 2360.	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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 one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	