Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL218033541M
Compliance #: HL218033841C

Date Concluded: August 19, 2024

Name, Address, and County of Licensee Investigated:
Brookside Senior Living
804 Benson Road
Montevideo, MN 56265
Chippewa County

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

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Inconclusive

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 resident was sexually abused when an unlicensed staff/alleged perpetrator (AP) was witnessed engage in kissing and close inappropriate intimate contact with a resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The AP was observed in the resident's bathroom embracing the resident while kissing him on the lips. The observed contact between the resident and the AP did not rise to the level of abuse. However, it could not be determined if the AP engaged in sexual contact with the resident prior to being observed kissing the resident. Although the resident repeatedly asked for the AP after the incident occurred, the resident has not shown any signs of emotional distress from the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The investigation included review of the resident record(s), facility internal investigation, facility

incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident's and staff at the facility.

The resident resided in an assisted living facility memory care unit with diagnoses including post-traumatic stress disorder, neurocognitive disorder with Lewy Bodies Dementia (a progressive form of dementia that leads to a decline in thinking, reasoning, and independent function), anxiety disorder, and depression.

The resident's assessment and plan of care indicated the resident was ambulatory, and independent with toileting and incontinence care. The assessment indicated the resident could easily get confused during conversations, was mildly disoriented, and required reminders and verbal cues from staff.

The resident's individual abuse prevention plan indicated the resident had poor safety awareness and could become agitated when he does not get what he wants.

A faxed communication to the resident's provider 45 days prior to the incident indicated the resident was having hypersexual behaviors over the past 3 months with staff and other residents.

The AP's personnel file included a performance improvement form 12 days prior to the incident which indicated the AP received a warning that working under the influence would not be tolerated and would result in corrective action leading up to termination of her employment.

The day of the incident a staff member texted leadership and reported at 12:50 p.m. the AP was observed in the resident's bathroom making out with the resident which made her feel very uncomfortable, and the staff did not want the AP working with the residents. The text communication indicated the AP was observed kissing the resident while the resident had his hands on the AP's body and the AP had her hands on the resident's face and neck area. When the staff saw the AP, the AP slammed the bathroom door shut.

A facility investigation indicated when leadership called the AP to the office, the AP denied kissing the resident, and stated the resident was always trying to put his arms around her and kiss her. The AP stated she had helped the resident get ready for the day and indicated she was assisting the resident with toileting when the staff saw them.

The resident's service delivery of care record indicated another staff, not the AP, assisted the resident to get ready for the day. The delivery record indicated during the time of the incident the AP had not provided toileting or incontinence care for the resident at the time she was witnessed kissing the resident in his bathroom.

When interviewed the staff who witnessed the incident stated the resident needed assistance to get up and ready for the day but was independent with toileting and incontinence care. The

staff witness stated she had not seen the AP for 10-15 minutes and needed assistance with another resident, so she went to look for the AP. The witness stated the resident's bathroom door was open slightly and she saw movement, then pushed the door open wide and saw the AP standing in the middle of the bathroom with her arms up and hands on the resident's face and neck, while the resident had his hands on the AP's waist and hip area and the two were kissing each other. The witness stated as soon as she opened the door the AP quickly slammed the bathroom door shut in the witness's face. The witness stated she was shocked and disgusted by what she had seen. The witness stated afterwards the AP came to her and asked if she had seen the resident trying to kiss her. The witness stated the AP told her the resident forced himself on her and was trying to "do things" with her but the AP would not let him. The witness stated the AP was embracing the resident and kissing the resident on the lips. The witness stated after the incident the AP appeared agitated and nervous. The witness stated the resident persistently asked about the AP, described the AP's appearance, and stated he needed to talk to her. The witness stated the resident does not ask about other staff at the facility just the AP.

The resident's psychiatric provider progress note 2 days after the incident occurred indicated staff reported the resident had sexual behaviors described as trying to kiss and inappropriately touch other resident's and staff, and indicated he was sad because he was "locked up" in the facility.

About one month after the incident occurred a provider progress note indicated the resident was seen for medication management and behavioral concerns. The resident continued to have sexual behaviors such as masturbating in front of staff. The note indicated the resident asked where the AP was several times before he was able to be redirected by staff. Staff reported the resident often brought up the AP by name.

A nurse's note about one month after the incident indicated the resident was repeatedly asking for the AP's phone number. Another month later a progress note indicated the resident was talking about and described the AP.

When interviewed several unlicensed personnel (ULP) staff stated the resident made inappropriate comments, and would try to touch, grab, or kiss them but he was easily redirectable. The staff stated the resident needed assistance to get up and ready for the day, reminders/ques throughout the day, but was independent with toileting and incontinence care. Staff indicated there was no reason for the AP to be in the resident's bathroom at the time the incident occurred.

One ULP staff stated the day of the incident when the AP reported for her shift she was mumbling, had extremely exaggerated reactions, statements, head, and body movements, with very odd behavior. The ULP stated she received a text message from leadership staff who indicated they wanted the AP to report to the office. The ULP stated the AP leaned in to look at the message, and her leg swung way out, like the AP was off balance. The ULP stated the AP

responded, “OH that’s me!” and the ULP got a strong smell of alcohol on the AP’s breath. The ULP stated the AP appeared to be under the influence and she did not feel comfortable leaving the residents in the AP’s care. The ULP stated she was relieved when leadership stated another staff would be covering the AP’s shift.

Another ULP stated she had not worked with the AP much, but reported the AP was vaping, acting weird, and appeared to be under the influence of something 12 days prior to the incident with the resident. When asked to describe “acting weird” the ULP stated the AP had touched a hospice resident inappropriately by running her hands up and down the resident’s bare legs while mumbling incoherently and kissed the resident’s bare feet with blisters on them. The ULP stated she told the AP to “STOP”, but the AP just smiled and laughed at the ULP, then the ULP told the AP to leave the resident’s room. The ULP stated the AP had inappropriate conduct toward the ULP, was overly friendly, and offered the ULP money, shoes, and clothing to engage in a relationship with the AP. The ULP stated she reported her concerns to leadership.

A nurse stated when interviewed the AP stated she was toileting the resident at the time the incident occurred, but the AP had not documented providing any toileting service at the time the incident occurred. The nurse stated it was strange the AP was observed standing in the middle of the bathroom with the door shut when there was no reason for her to be in the resident’s bathroom. The nurse stated since the incident the resident had obsessive repetitive questions about the AP.

When interviewed facility leadership denied being told the AP touched, kissed the feet, and caressed the legs of a dying resident. Facility leadership stated staff had reported the AP smelled of alcohol, was acting strange, vaped in the building, and had strange conduct like holding the resident’s feet and talking to them, and the AP’s conduct made staff feel uncomfortable. Leadership staff stated the ULP received a warning about her conduct, then the incident with kissing the resident was reported several days later. Leadership indicated the witness was a reliable reporter and they had no reason not to believe what was reported.

When interviewed the AP denied having any disciplinary actions or conduct concerns at the facility. The AP denied any wrongdoing, and stated the resident grabbed her head and kissed her. The AP denied being under the influence of anything, but indicated she did not recall the conduct concerns with staff and resident’s due to taking extra medication for anxiety those days which clouded her memory.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: No, did not respond.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility investigated the incident, and 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.

You may also call 651-201-4200 to receive a copy via mail or email.

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
	21803	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE SENIOR LIVING	804 BENSON ROAD MONTEVIDEO, MN 56265

(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: #HL218033541M/#HL218033841C On August 5, 2024, 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 65 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL218033541M/#HL218033841C, tag identification 0630.	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.	
0 630 SS=G	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a individual abuse prevention plan (IAPP) with specific interventions for each known vulnerability for one of one resident (R1) reviewed. Although the facility was aware R1 had hypersexual behaviors, R1's assessment did not identify the behavior, and R1's IAPP did not include the behavior or specific interventions for staff on how to respond, manage, or monitor the occurrence of the behavior. R1 was harmed when unlicensed personnel (ULP)-A was observed embracing and kissing R1 on the lips, then R1 persistently asked for the ULP for months after the incident occurred. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	0 630		

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0 630	Continued From page 2 Findings include: R1 was admitted to the licensee memory care unit on October 28, 2022, with diagnoses including post-traumatic stress disorder, neurocognitive disorder with Lewy Bodies Dementia (a progressive form of dementia that leads to a decline in thinking, reasoning, and independent function), anxiety disorder, and depression. R1's assessment dated February 17, 2024, indicated R1 was ambulatory, and independent with toileting and incontinence care. The assessment indicated R1 could easily get confused during conversations, was mildly disoriented, and required reminders and verbal cues from staff. R1 individual abuse prevention plan (IAPP) dated February 17, 2024, indicated the resident had poor safety awareness and could become agitated when he does not get what he wants. The IAPP failed to identify R1 had hypersexual or sexually inappropriate behaviors. On March 28, 2024, at 10:34 a.m. a faxed communication to R1's provider indicated the facility reported concerns R1 had hypersexual behavior noted in the past 3 months, and was getting more direct with staff and other residents. The communication indicated R1 would masturbate in his room while in bed, and staff provided privacy. On May 11, 2024, at 12:50 p.m. ULP-C texted the Licensed Assisted Living Director (LALD)-B and reported ULP-A was observed in R1's bathroom "making out" with R1 which made her feel very	0 630		

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0 630	Continued From page 3 uncomfortable, and did not want ULP-A working with the residents. The text communication indicated the ULP-A was observed kissing R1 while R1 had his hands on ULP-A's body and the ULP-A had her hands on R1's face and neck area. When ULP-C saw the ULP-A and R1 kissing, ULP-A slammed the bathroom door shut. The staff indicated afterwards, ULP-A stated R1 had tried to kiss her and touch her, but ULP-C indicated that was untrue because ULP-A was kissing and touching R1 too. A undated facility investigation indicated when leadership called ULP-A to the office, she denied kissing R1, and stated R1 was always trying to put his arms around her and kiss her. ULP-A stated R1 was "perverted" and was always trying to touch her. ULP-A stated she helped the resident get ready for the day and indicated she was assisting R1 with toileting when the staff saw them. On May 13, 2024, a psychiatric provider progress note 2 days after the incident occurred indicated staff reported R1 had sexual behaviors described as trying to kiss and inappropriately touch other resident's and staff. R1's service delivery of care record after the incident occurred included instructions for staff to utilize 2 assist as needed (PRN), and notify the nurse if R1 was using inappropriate behaviors (touching, language, grabbing, masturbating), initiated on May 13, 2024, R1's assessment and IAPP post incident dated May 13, 2024, indicated R1 was at risk to be abused by others, had a mental illness, PTSD, anxiety, depression, Lewy body dementia, and paranoia. The IAPP indicated R1 was vulnerable	0 630		

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0 630	Continued From page 4 due to poor safety awareness and had inappropriate sexualized gestures toward females. R1 had speech communication issues, difficulty finding his words, and was unable to report abuse/neglect. R1's IAPP failed to include specific interventions to minimize identified risks for abuse including R1's sexually inappropriate behaviors toward resident's and staff. R1's care plan was requested, the licensee provided a document titled "plan of care" dated post incident May 13, 2024, which included a list of services for R1. The plan of care failed to include any of R1's identify vulnerabilities or risks with specific interventions to minimize those concerns including utilizing 2 staff if R1 had sexually inappropriate behaviors, or reporting those concerns to nursing. On June 17, 2024, a psychiatric provider progress note indicated R1 was seen for medication management and behavioral concerns. R1 continued to have sexual behaviors such as masturbating in front of staff. The note indicated R1 asked "where is ULP-A" several times before he was able to be redirected by staff. Staff reported to R1's provider the resident often brought up ULP-A by name. On June 3, 2024, a nurse's progress note indicated R1 was repeatedly asking for ULP-A's phone number. On July 27, 2024, at 9:22 p.m. another progress note indicated R1 was talking about the ULP-A and described ULP-A as "tall, beautiful, and had a really slim body." During interview on August 6, 2024, at 1:18 p.m. Registered Nurse (RN)-D, Director of Health	0 630		

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0 630	Continued From page 5 Services, stated staff were supposed to report any incidents of R1 having inappropriate conduct, give him space, and tell a nurse. RN-D stated R1 had very sexualized behaviors and staff were trained to redirect, reapproach, and handle those types of behaviors. A facility policy and procedure titled, "Individual Abuse Prevention Plan," dated March, 21, 2024, indicated the residents had the right to be free from maltreatment. An individual abuse prevention plan was developed for each assisted living resident. Section 4. indicated the individual abuse prevention plan would include assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults. Section b. The resident's risk of abusing other vulnerable adults Section c. Specific measures to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 630		