*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL232174243M
**Compliance #:** HL232177178C

**Date Concluded:** February 14, 2023

**Name, Address, and County of Licensee Investigated:**
Regent at Burnsville
14500 Regent Lane
Burnsville, MN, 55306
Dakota County

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

**Evaluator's Name:** Angela Vatalaro, 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), a staff member, sexually abused the resident when he fondled the resident's genitals with digital penetration.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. Video footage showed the AP digitally penetrate the resident's vagina and showed the AP rub the resident's external genitalia vigorously.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and the resident's family. The AP declined an interview. The investigator contacted law enforcement and reviewed the law enforcement report. The investigation included review of the resident's medical records, emergency room records, incident report, service delivery records, internal investigation notes, the AP's personnel file, and facility policies

related to maltreatment. Also, the investigator observed the resident's living space and incontinent cares.

The resident resided in an assisted living facility. The resident's diagnoses included history of a stroke and left sided weakness. The resident's service plan included assistance with dressing, grooming, bathing, toileting, incontinent care, transfers using a mechanical lift, and used a wheelchair. The resident's assessment indicated the resident was oriented to person, forgetful, and confused.

The facility's internal investigation indicated one day facility leadership received a report the AP put his hands and fingers into the resident's vagina, rectum area, and rubbed her intimate parts.

The law enforcement report indicated video footage showed the AP interacting with the resident on two different occasions on the same day. During the first occasion, the video showed the AP getting the resident's bed ready. The AP dried the resident's groin area with a towel and applied lotion. The AP's right wrist was seen moving back and forth aggressively with his hand between the resident's buttocks. During the second occasion on the same day, the resident was lying in her bed, and the AP took off the resident's brief and wiped the resident's vaginal area with a wipe. The AP discarded the wipe and applied lotion. The AP then wiped the residents' buttocks and discarded that wipe and the brief. The AP then continued to aggressively rub the resident's vagina with his hand. On the video, the resident was seen tensing up and flinching her body while vocalizing as if she was in pain. The AP put a new brief under the resident and rolled her onto her back. The AP then placed his fingers into the resident's vagina; the AP's wrist was turned so his palm faced the ceiling and he repeatedly moved his fingers back and forth into the resident's vagina.

The law enforcement report indicated the AP was arrested. The same report indicated during interview, the AP admitted he used his finger to penetrate the resident's vagina which was something he was never trained to do and was beyond his scope of job duties.

The resident's emergency room records indicated the resident was evaluated by a sexual assault nurse examiner (SANE).

The law enforcement report indicated the SANE nurse examined the resident and excoriation was noted on the labia minora. The nurse stated excoriation meant the top layer of the skin rubbed off. She did not feel the excoriation observed on the resident was caused by gentle cleaning, it was caused by repeated vigorous rubbing against the area.

The AP's personnel file indicated the AP received vulnerable adult abuse training.

During an interview, leadership stated the resident was incontinent and required incontinent care which included cleaning the resident's skin and application of barrier cream. Leadership

stated there would be no care related need for the AP to place his hands and fingers into the resident's vagina or buttocks and move them back in forth. Leadership stated the facility conducted an internal investigation and interviewed other residents who the AP provided cares to. Leadership stated they did not identify concerns with other residents.

During an interview, the registered nurse (RN) stated the AP received vulnerable adult training which included identification of vulnerable adults, forms of abuse, what maltreatment was, and mandated reporting upon hire and annually. The RN  tated all facility staff received training upon hire and annually. She stated all staff retrained on the topics during the facility's internal investigation.

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:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(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.
(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, unable due to cognition.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: No, declined an interview.

**Action taken by facility:**
The facility conducted an internal investigation, provided re-education to staff, added services to reflect two staff assist for the resident's personal cares, and monitored the resident.

**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
Dakota County Attorney
Burnsville City Attorney
Burnsville Police Department

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 23217 | A. BUILDING: _____ B. WING _____ | C 01/10/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| REGENT AT BURNSVILLE | 14500 REGENT LANE BURNSVILLE, MN 55306 |

| (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<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL232177178C/#HL232174243M<br><br>On January 10, 2023, 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 151 residents receiving services under the provider's Assisted Living with Dementia Care license.<br><br>The following correction order is issued for #HL232177178C/#HL232174243M, tag identification 2360. | 0 000 | Minnesota Department of Health is documenting the State Licensing 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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<br><br>Residents have the right to be free from physical, | 02360 | | |

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| 02360 | Continued From page 1<br>sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interviews and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was abused.<br><br>The findings include:<br><br>The Minnesota Department of Health (MDH) issued a determination that abuse occurred, and 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. | 02360 | No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag. | |