DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL259975141M
Compliance #: HL259976903C

Date Concluded: October 7, 2024

Name, Address, and County of Licensee Investigated:
Ecumen Detroit Lakes The Cottage
1435 Madison Avenue
Detroit Lakes, MN 56501
Becker County

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

Evaluator's Name: Barbara Axness, 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 alleged perpetrator (AP), an unlicensed personnel (ULP), sexually abused the resident when he forced the resident to have sex with him.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined sexual abuse was inconclusive. There was not a preponderance of evidence that sexual abuse occurred. Due to cognitive impairment, the resident was not able to be interviewed. The AP deferred all questions to his attorney.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, the police department, the AP's attorney, hospice, and the primary care provider (PCP). The investigation included review of the resident's records, internal investigation documentation, facility incident reports, personnel files, staff schedules, law enforcement reports, and related facility policies

and procedures. Also, the investigator observed care and services in the facility and the resident's room.

The resident resided in an assisted living memory care unit. The resident's diagnoses included mild cognitive impairment. The resident's service plan included assistance with dressing, grooming, bathing, escorts, and medication administration. The resident required reassurance, redirection, and reorientation due to severe cognitive impairment. The resident's assessment indicated the resident was dependent on staff to perform most activities of daily living. The resident was noted to have impaired short- and long-term memory and was unable to provide accurate information consistently. There was no noted history of the resident making sexual comments or allegations.

The AP's employee file included disciplinary action for failing to complete assigned tasks, taking breaks during four-hour shifts, and for making "threatening and inappropriate comments towards another team member." The corrective action form was not signed by the AP. The employee received a final written warning approximately one month before the allegations were reported. The AP was put on suspension related to allegations of sexual harassment towards a team member on the same day that the resident stated someone had sex with her. The AP passed a background study prior to beginning employment at the facility.

A police report was not available as the incident was still an open investigation.

Facility documents indicated the resident reported that someone had "hurt her" and "forced her to have sex and it hurt."

The facility's internal investigation indicated the resident told unlicensed personnel (ULP) she had been raped. Camera footage from the evening prior was reviewed. The AP was noted to have been assisting the resident in her room with toileting, grooming, and oral cares from 7:21 p.m. to 7:27 p.m. Other ULP were noted in and out of the resident's room providing care and services throughout the day.

The internal investigation included written statements from several staff members. A nurse wrote that a ULP "told me that [resident] stated her brothers had raped her last night. Writer stated that there were two female staff working last night. [ULP] replied that [alleged perpetrator] worked the PM shift." The nurse assessed the resident and "...saw an open area to the left groin. Area had serosanguinous [a type of wound drainage composed of blood] drainage..."

The registered nurse's (RN) statement included "I was stopped by [ULP] who asked, "have you heard what's going on with [resident]?" I answered, no, and she stated that resident had expressed that her brothers were having sex with her...Dime sized excoriated lesion noted to left groin fold. Resident was scratching at area and stated she had pain in her genitals. RN asked resident if someone had harmed her. She stated, yes, that her brothers were having sex with

her. RN asked when this had occurred. Resident stated, "all the time". When asked if resident could name the alleged perpetrators, resident states that there are too many of them. RN updated the provider.

The facility interviewed ULP two days after the initial allegations were made. The ULP reported that the AP was "bragging to her and other team members about [resident] kissing him." The ULP reported the AP "thought it was cute." Another ULP showed the resident a picture of the AP on her phone and the resident stated the person in the photograph was her brother. The facility's internal investigation lacked evidence the AP was interviewed about the allegations or how the facility responded to allegations that the AP may have been involved with the incident.

The conclusion of the investigation indicated there was no evidence that anyone harmed the resident in question. Video audited for staff contact with resident and no suspicious activity seen on video. Resident assessed morning [after allegations were made] and reported no pain or concerns.

During investigative interviews, multiple unlicensed personnel (ULP) stated the AP made them uncomfortable and sexually harassed other female staff. The ULP stated the AP discussed his sex life in front of residents, he followed younger female staff around the facility, started rumors that certain staff were having sex with him in resident rooms, and would brush up against other staff in inappropriate ways. The ULP stated the AP would come in to visit a different resident at 11:00 p.m. when he was not on the clock, and they found it strange he would come in and visit when he was not working. The ULP stated if they brought concerns to management about the AP's inappropriate behavior and sexual harassment, they were told they were targeting the AP or trying to get him fired and they felt their concerns weren't taken seriously. The ULP who reported the resident's initial concern was told by management that her report to the LPN and the RN weren't consistent, and she was just trying to get the AP in trouble. Several ULP stated the resident frequently called the AP her brother and one day the resident kissed the AP on the cheek, saying he was her brother. ULP stated the resident lived at the facility for several years and prior to this, had never made comments about having sex or any other sexual statements.

During an interview, a facility nurse stated she interviewed all employees after the resident reported someone had sex with her and no one had identified the AP as a suspect. The facility nurse stated the resident called the AP her son but hadn't heard her refer to him as her brother. The nurse stated she was not aware that multiple staff members had concerns about sexual harassment by the AP.

When contacted for an interview, the AP deferred questions to his attorney.

In conclusion, the Minnesota Department of Health determined sexual 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;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(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.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No, due to cognitive impairment.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Declined

Action taken by facility:
The facility investigated the incident and the AP resigned shortly after conclusion of the investigation.

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
Becker County Attorney
Detroit Lakes City Attorney
Detroit Lakes Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25997	A. BUILDING: ____ B. WING ____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN DETROIT LAKES THE COTTAGE	**1435 MADISON AVENUE DETROIT LAKES, MN 56501**

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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: #HL259975141M/ #HL259976903C On August 28, 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 17 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL259975141M/ #HL259976903C, tag identification 0620.	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.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

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(a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.

The requirement in Minnesota Statute section 626.557, Subd. 3 is:
(a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:
(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or
(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4).
(b) A person not required to report under the provisions of this section may voluntarily report as described above.
(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.
(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

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0 620	Continued From page 2 (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to report an allegation of suspected abuse to Minnesota Adult Abuse Reporting Center (MAARC) within 24 hours of staff becoming aware of the incident for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included mild cognitive	0 620		

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impairment.

R1's service plan dated August 28, 2024, included assistance with dressing, grooming, bathing, escorts, and medication administration. The resident required reassurance and redirection, as well as reorientation due to severe cognitive impairment.

R1's assessment dated May 24, 2024, indicated the resident depended on staff to perform most activities of daily living. The resident was noted to have impaired short and long term memory and was unable to give accurate information consistently. There was no noted history of the resident making sexual comments.

R1's progress note dated July 29, 2024, indicated staff had reported that "resident had expressed that her brothers were having sex with her."

R1's progress note dated August 1, 2024, indicated management had "reviewed all camera footage surrounding the time frame of concern. Informed son that nothing of concern was noted on the camera footage including no persons of concern entering the resident's room or spending concerning amount of time in the resident room." The resident's family declined any further action and that they felt the report "was a result of past trauma..."

R1's progress note from August 24, 2024, indicated "Staff report resident came out of room and asked if she had sex. Staff asked why she would ask that and resident stated her pants were not on."

The police report was requested, but not provided as the case was still open and under

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investigation.

The complaint document indicated R1 complained someone had "hurt her" and "forced her to have sex and it hurt."

The facility's internal investigation indicated the incident occurred on July 29, 2024, after the resident told a ULP she had been raped. Camera footage from the evening of July 28, 2024, through July 29, 2024, was reviewed by management. The alleged perpetrator (AP) was noted to have been assisting the resident with toileting, grooming, and oral cares from 7:21 p.m. to 7:27 p.m. Other ULP were noted to have been in and out of the resident's room to provide care and services.

The internal investigation included written statements from several staff members. Licensed practical nurse (LPN)-B wrote on July 30, 2024, at 1:42 p.m., that a ULP "told me that [resident] stated her brothers had raped her last night. Writer stated that there were two female staff working last night. [ULP] replied with that [alleged perpetrator] worked the PM shift." LPN-B went to assess the resident and "...saw an open area to the left groin. Area had serosanguinous [a type of wound drainage composed of blood] drainage..."

CNS-A's statement was dated July 29, 2024, at 3:00 p.m., and included "I was stopped by [ULP] who asked, "have you heard what's going on with [resident]?" I answered, no, and she stated that resident had expressed that her brothers were having sex with her...Dime sized excoriated lesion noted to left groin fold. Resident was scratching at area and stated she had pain in her genitals. RN began to examine the area and noted a uterine prolapse. LPN stated she had not

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0 620	Continued From page 5 noticed that. RN asked resident if someone had harmed her. She stated, yes, that her brothers were having sex with her. RN asked when this had occurred. Resident stated, "all the time". When asked if resident could name the alleged perpetrators, resident states that there are too many of them. RN called provider to report resident ' s claim and determine if resident has history of prolapse or STIs [sexually transmitted infections]. Provider referred to resident chart and later notified RN that this was not in resident history. RN notified [management] to determine need to file a VA report. It was relayed that the resident is a 96-year-old, disoriented female with diagnosis of dementia. Recently requiring bowel care including suppositories due to constipation that has resulted in bleeding hemorrhoids. Resident had a bowel movement which may have caused the uterine prolapse and feeling of pressure in her vaginal region. The incontinence of stool may have resulted in the skin lesion noted to left groin...RN received clarification from [RN-D] that no VA will be filed at this time." As a result of the facility's investigation, the "resident's care plan adjusted to reflect delusions in the IAPP [individual abuse prevention plan]. Behavior documentation updated so team members can document if statements are made by resident again in the future." The conclusion of the investigation indicated, "After investigation, there is no substantiated evidence that anyone harmed the resident in question. Video audited for staff contact with resident and no suspicious activity seen on video. Resident assessed morning of 7/30/2024 and reported no pain or concerns. Not exhibiting signs of anxiety. No reports of fear. Outside party reported statements, DLPD [Detroit Lakes Police Department] involved in investigation." Clinical	0 620		

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0 620	Continued From page 6 nurse supervisor (CNS)-A indicated the incident was not reportable on August 2, 2024. Two ULP were interviewed by facility management on July 31, 2024, two days after the incident was initially reported. One ULP reported that the AP was "bragging to her and other team members about [resident] kissing him." The ULP reported the AP "thought it was cute." Another ULP showed the resident a picture of the AP on her phone and the resident stated the person in the photograph was her brother. On August 28, 2024, at 11:50 a.m., clinical nurse supervisor (CNS)-A stated she had been notified the resident mentioned her brothers were having sex with her and they initiated an investigation into the allegations. CNS-A stated she "was advised not to file it as a VA [a MAARC report]. The resident is a memory care resident and she has a history of making confused statements, I didn't want to disregard it but it didn't seem to be anything evident at the time making it seem like it was true." CNS-A stated some of the employees who had reported concerns about the AP or suggested he was responsible for sexually abusing the resident "were pot-stirrers." On August 28, 2024, at 12:20 p.m., ULP-C stated R1 would frequently call the AP her brother. On August 28, 2024, at 3:05 p.m., ULP-E stated R1 would call the AP her brother and she had observed the resident kiss the AP on the cheek thinking he was her brother. ULP-E stated she had shown the resident a picture of the AP once and she said that's my brother. On August 29, 2024, at 10:50 a.m., ULP-F stated R1 would usually refer to the AP as her brother	0 620		

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and they had let management know about it.

On August 29, 2024, at 12:20 p.m., corporate registered nurse (RN)-D stated she had assisted with some, but not all of the investigation. RN-D stated there was no perpetrator identified and nothing suspicious noted on the camera footage and the resident's power of attorney didn't want to pursue any further investigation so she had agreed it would not be reportable. RN-D stated she was not made aware of the resident calling the AP her brother and had she known that, she would have approached the investigation differently. RN-D stated the AP's name was never mentioned to her and she was not aware of concerns raised by other employees about the AP. RN-D stated, "We were kinda left in the dark and like there's serious allegations right and we can't just take every male caregiver out of work with some sort of allegation and say well you're a male, she's reporting sexual abuse. It's a really touchy subject..."

On August 29, 2024, at 12:45 p.m., CNS-A stated at the time the allegations were made, there was no one identified as an AP and "we were going to do our due diligence to see if there was any merit to the statement she made before filing [a MAARC report] but somebody kinda took it upon themselves to file before we could look into it fully." CNS-A stated the police came without her knowledge and the facility had not called police to investigate after the resident reported someone having sex with her. CNS-A stated, "We weren't given the opportunity to decide if we were going to file or not, the staff took it upon themselves [to report it to MAARC.]" CNS-A confirmed the facility did not a do a report because "we knew it had already been reported." CNS-A stated she was not aware the facility had an obligation to file a

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0 620	Continued From page 8	0 620		

report and they had contacted their legal department and she was under the impression they didn't have to do a report. CNS-A stated she was "not made aware of any concerns that were sexual in nature" with the AP and the resident and "If I was aware of concerns of a sexual nature, I would have taken action." CNS-A stated the resident would frequently make comments that were not based in reality "for instance, my husband was here and someone shot him and killed him so obviously we're not going to investigate a homicide, other things like that." CNS-A confirmed the resident had lived at the facility for four years and had not previously made any sexual comments.

On September 3, 2024, at 2:20 p.m., primary care provider (PCP)-I stated when she was updated on the resident's allegations, she told staff they needed to file a MAARC report and was under the impression they had done so. PCP-I stated the allegations would be reportable and they should have been reported. PCP-I stated she was not told there might be an AP.

The licensee's Facility Responsibilities for Reporting Allegations policy indicated all allegations/occurrences of all types of staff-to-resident abuse must be reported to the administrator and to other officials, including the State Survey Agency and adult protective services, where state law provides for jurisdiction. This includes, but is not limited to: All allegations/occurrences of physical, sexual, mental, and verbal abuse, including deprivation of goods and services by staff, and involuntary seclusion perpetrated by staff. All reports from residents of abuse perpetrated by staff; allegations must not be dismissed on the basis of a resident's cognitive impairment(s) in nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25997	A. BUILDING: ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN DETROIT LAKES THE COTTA	**1435 MADISON AVENUE DETROIT LAKES, MN 56501**

(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
0 620	Continued From page 9 homes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days :	0 620		