Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL28209001M
Compliance #: HL28209002C

Date Concluded: June 22, 2022

Name, Address, and County of Licensee Investigated:
Birchview Gardens Assisted Living
103 Third Street North
Hackensack, MN 56452
Cass County

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

Evaluator's Name: Angela Vatalaro, RN
Special Investigator

Finding: Substantiated, individual responsibility

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.

Allegation(s):
The alleged perpetrator (AP), a staff member, sexually abused the resident when he had sexual intercourse with the resident.

Investigative Findings and Conclusion:
Abuse was substantiated. The AP was responsible for the maltreatment. The AP picked the resident up from the facility, drove to a ballpark, and had sexual intercourse while the AP worked for the facility.

The investigation included interview with administrative staff. The investigation included interviews with the resident's guardian, and the AP. In addition, the investigator contacted law enforcement and reviewed law enforcement report. The investigation included review of the resident's medical records, the facility's internal investigation, the AP's personnel file, and policy and procedures related to maltreatment and professional boundaries.

The resident's medical record was reviewed. The resident's diagnoses included mental health conditions. The resident's service plan indicated the resident required assistance with behavior monitoring, housekeeping, laundry, and medication administration. The resident's abuse prevention plan indicated the resident was at risk of being abused and had a history of sexual exploitation. The resident's nursing assessment indicated the resident was alert and oriented.

A review of the facility's incident report and internal investigation indicated the resident reported to a facility staff member her and the AP had a relationship and showed a text message sent by the AP about a kiss in the elevator. During the internal investigation interview, the resident stated while the AP worked at the facility, they exchanged phone numbers. The resident stated she had a crush on the AP. The AP told the resident not to tell anyone he gave her his phone number because he did not want to lose his job. The resident stated the AP sent her a picture of his penis. Afterwards the resident sent the AP a picture of her breasts. On one occasion, the resident stated she texted the AP to come to the facility to talk. At 10:00 p.m., she met the AP outside of the facility. The AP told her to get into his vehicle. The resident stated they drove off because the facility had security cameras and did not want anyone to see them. They drove to a ballpark and engaged in sexual intercourse. After sex, the AP dropped the resident back off at the facility. The resident stated facility staff did not see her leave that evening or return. The resident stated she did not disclose her relationship with the AP and kept it a secret because she wanted a relationship with the AP. After sex, the AP told her he just wanted to be friends and he could not have a relationship with her.

A review of law enforcement report indicated law enforcement interviewed the resident and the AP. The AP stated the resident flirted with him and told him she liked him. The AP stated he gave the resident his phone number and texted with the resident. The AP said he sent the resident a picture of his penis. The AP stated the resident did not request the picture, and said he did this "out of the blue." The AP said he knew this was not something he should be doing. The AP stated one evening he received a text from the resident asking him to go to the facility to talk. The AP went to the facility, picked the resident up, went to a ballpark, and engaged in sexual intercourse with the resident. After sex, the AP stated he told the resident this should not have happened and brought the resident back to the facility. The AP said he should not have done this because he was there to take care of the residents. The AP denied having relationships like this with other residents, but stated other residents flirted with him and liked him.

A review of the AP's personnel file indicated the AP received vulnerable adults and professional boundaries training. The same personnel file indicated the AP read and acknowledged the facility's policy on professional boundaries which indicated all staff were not to engage in a relationship outside of a professional relationship outside of the workplace.

During an interview, facility leadership stated the AP was aware of the facility's policy and received training on vulnerable adults and professional boundaries. The AP stated during

internal investigation that he knew he was not supposed to exchange phone numbers or have a relationship outside of a professional one with the resident.

During an interview, the AP stated he received training on vulnerable adults and professional boundaries when hired. The AP stated he met the resident while he worked at the facility. The AP stated he had sexual intercourse with the resident.

A review of the law enforcement report indicated that the case was ongoing.

In conclusion, 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:
(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, attempted but did not reach.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation and contacted law enforcement. The AP is no longer employed by the facility.

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.

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
Cass County Attorney
Hackensack City Attorney
Hackensack Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28209	A. BUILDING: _____ B. WING _____	C 06/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

(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 *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.01 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL28209001M/H28209002C On March 15, 2022 through June 7, 2022 , the Minnesota Department of Health conducted an investigation at the above provider, and the following correction orders are issued. At the time of the investigation, there were 39 residents receiving services under the provider's Assisted Living/with Dementia Care license. The following correction order was issued for HL28209001M/HL28209002C, 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 License Providers. 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 surveyors' 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 subd. 1, 2, and 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: Based on interviews and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was abused. The findings include: On June 22, 2022, 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 required for tag 2360. Please refer to the public maltreatment report (sent separately) for details.	