

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL286051452M
Compliance #: HL286052899C

Date Concluded: September 5, 2022

Name, Address, and County of Licensee

Investigated:

Summit Hill Senior Living
1824 Old Hudson Road
St. Paul, MN 55119
Ramsey County

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

Evaluator's Name:

Maerin Renee, RN, Special Investigator

Finding: Inconclusive

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.

Initial Investigation Allegation(s):

The alleged perpetrator (AP1) abused the resident when she engaged in sexual relations with the resident.

The alleged perpetrator (AP2) financially exploited the resident when she borrowed fifty dollars from the resident.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was inconclusive. Although text messages between AP1 and the resident indicated an attempt to schedule a sexual encounter, text messages also indicated AP1 and the resident had been unable to meet as planned. The resident's account of the evening was inconsistent with recorded video evidence. AP1 denied the allegation.

The Minnesota Department of Health determined financial exploitation was inconclusive. Text messages between AP2 and the resident indicated AP2 requested to borrow money from the resident. The resident reported he lent AP2 fifty dollars which she did not pay back. However, when the resident was interviewed during the facility's internal investigation, the resident stated he did not lend money to AP2 because he did not have any money to lend her.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator toured the facility, observed staff/resident interactions, reviewed AP1 and AP2's personnel files, staff training files, resident records, incident reports, policies and procedures related to vulnerable adults and professional boundaries, and the internal investigation. The investigator did not have access to facility surveillance video.

The resident resided in an assisted living facility. The resident's diagnoses included bipolar disorder, obsessive-compulsive disorder, post-traumatic stress disorder, major depressive disorder, and generalized anxiety disorder. The resident's service plan included assistance with medication management, meals, and housekeeping. The resident's assessment indicated he was independent with personal cares.

During an interview, an administrator said the resident reported he and AP1 had sexual relations in his apartment. The resident presented copies of text messages between him and AP1 attempting to schedule a sexual encounter. The resident said AP1 brought him marijuana and beer at his request and told him to be ready for her. The resident said he took a Viagra pill and waited for her. After the alleged sexual encounter, the resident stated AP1 slept in his room for over an hour, until he woke her up to complete her shift.

During the internal investigation, the resident reported AP1 entered his room at 10:00 p.m. and brought him marijuana and a can of beer. AP1 was called away to an emergency and told the resident to be ready for her when she returned. The resident said AP1 returned to his apartment, and they had sexual intercourse. The resident stated AP1 fell asleep on his bed, and he woke her up at 4:00 a.m. so she could get back to work.

The administrator reviewed video from that evening and saw the resident was in and out of his room for several hours. The administrator did not see any staff member enter his room until 3:14 a.m., when AP1 entered and then exited at 3:30 a.m.

Review of the text messages supplied by the resident, between the resident and AP1, indicated a sexually charged conversation attempting to arrange a sexual encounter that evening. The text messages indicated, however, that AP1 and the resident were not able to arrange a sexual encounter due to AP1's workload.

Per the internal investigation document, the police officer stated there would be no investigation, as both parties involved were consenting adults and the resident had taken Viagra prior to the occurrence, and the case would be closed.

During an interview, AP1 denied the allegation. AP1 said the text messages were flirting and she never had sex with the resident.

During an interview, an administrator stated the resident reported AP2 had asked him for money. The administrator read text messages between the resident and AP2, indicating AP2 had asked to borrow money from the resident. The resident told the administrator that he did not lend AP2 money because he didn't have any money at the time. However, the resident filed a MAARC report stating he had lent AP2 fifty dollars, which AP2 never paid back.

Text messages provided by the resident indicated AP2 had asked to borrow \$50-\$70 from the resident. The text messages did not indicate whether or not the resident loaned AP2 the requested money. AP2 was no longer an employee of the facility when the resident filed his complaint and did not respond to requests for interview.

In conclusion, the Minnesota Department of Health determined abuse and financial exploitation 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; Stop here if it is not a restraints issue or sexual abuse.

(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.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9

"Financial exploitation" means:

(b) In the absence of legal authority a person:

(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;

(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or

(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: No, the resident was unavailable for interview during the investigation.

Family/Responsible Party interviewed: No, the family member did not respond to request for interview.

Alleged Perpetrator interviewed: AP1, yes. AP2, no. AP2 did not respond to requests for interview.

Action taken by facility:

The facility filed a MAARC report and re-trained staff on personal boundaries, HIPPA, and vulnerable adult policies and procedures. AP1 and AP2 are no longer employed with the facility.

Action taken by the Minnesota Department of Health:

No further action required.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/11/2022
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NAME OF PROVIDER OR SUPPLIER SUMMIT HILL SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1824 OLD HUDSON ROAD SAINT PAUL, MN 55119
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(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	<p>Initial Comments</p> <p>Initial comments On August 11, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL286052899C/#HL286051452M. No correction orders are issued.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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