Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL289653261M
Compliance #: HL289653364C

Date Concluded: October 25, 2024

Name, Address, and County of Licensee Investigated:
Amira Choice Roseville
2996 Cleveland Avenue North
Roseville, MN 55113
Ramsey County

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

Evaluator's Name: Jennifer Segal RN, BSN
Nurse Investigator
Jessica Sellner, RN, BSN
Nurse 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), facility staff member, sexually abused the resident when the resident reported the AP raped her.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The resident reported the AP raped her. The DNA collected during the resident's sexual assault exam identified a Y chromosome (male) was present. The DNA was tested against the AP's DNA and the results came back indicating the resident's sample was not adequate to complete further DNA testing. The AP denied any sexual contact with the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family, law enforcement, a case manager and hospital staff. The investigation included review of the resident facility record, facility internal investigation, personnel files, staff schedules, related facility policy and procedures, hospital records and law enforcement report. Also, the investigator observed staff and resident interactions and care provided on the unit.

The resident resided in an assisted living memory care unit with diagnoses including dementia with severe psychotic disturbance, early onset Alzheimer's disease, and aphasia (communication and comprehension disorder). The resident's service plan included assistance with all personal care, including mobility, toileting, dressing, and bathing. The resident's assessment indicated an overall decline in physical and cognitive health, including weight loss, frequent falls, and elected hospice services.

A law enforcement report indicated they were called to the facility for a possible sexual assault. The resident was in her apartment with a visitor and pointed to the bed and stated something bad happened. With further questions, the resident was asked if a staff member hurt her, and the resident mumbled yes. The resident was asked if the staff member was female, and the resident stated no. The resident was asked if the staff member was male, and the resident stated yes. The resident was asked if the specific AP by name hurt her, and after hesitation, the resident stated yes. The resident was asked if she was hurt, "down here," pointing to the pelvic area, and the resident stated yes. The resident was asked if the AP raped her, and the resident stated yes. The police report indicated leadership staff at the facility stated the AP was the primary caregiver for the resident that morning. The AP’s duties included bathing, “cleaning up after,” and monitoring the resident, so the AP was alone in the room with the resident that day. The officer provided options for the resident and family to investigate further, and the resident was taken to the hospital for a sexual assault exam.

The sexual assault exam notes indicated the resident’s family was present for the exam. The resident was primarily non-verbal through the exam and provided some soft, brief responses to questioning. The family was asked to recount the events. Family stated when they were in the residents’ room visiting, the resident pointed to the bed across the room and gestured her hand in a circle around the area and said, “Something bad happened.” Family stated the resident looked scared, “It was a different scared look, like she didn’t want to say something.” Family asked the resident if someone hurt her and she said yes. Family stated there were only 2 males that worked at the facility and the resident identified it was the AP. The family stated they asked the resident how he hurt her and when the resident did not answer family gestured to the pelvic area and asked if the AP raped her, and the resident stated yes. The family stated when they assisted the resident to the bathroom the previous day she complained of vaginal pain and was still having some pain on exam. During the vaginal exam light creamy greenish tinted fluid was present at the cervix os (the opening between the cervix and the upper part of the uterus). Swabs were collected for DNA testing.

The resident was seen by a provider approximately one week following the sexual assault exam. The notes indicated the resident has been nonverbal so much of the history was obtained by family who was present at the follow up visit. Family stated the resident had personality changes in the past months. The resident had an increase in crying and social isolation. The family member reported the resident was no longer complaining of pelvic or perineal pain, but seemed to be, “more scared and sad more than anything.” The note indicated nursing staff confirmed the resident’s mood had been unusual from her baseline personality which include crying more and declining to come out of her room more often. Since the resident returned from the hospital the resident seemed calmer when not being cared for by male staff, but, “still withdrawn and isolating following trauma.”

Law enforcement stated the DNA from the resident vaginal swab taken during the sexual assault exam returned with a Y chromosome in the resident's vaginal tract. Law enforcement stated a Y chromosome indicated male DNA was present and the AP was contacted to provide samples for testing to see if the Y chromosome matched the AP's DNA. The AP provided a sample of DNA.

The final DNA result came back indicating the residents DNA sample was inadequate to determine if the Y chromosome was a match to the AP. Law enforcement indicated a Y chromosome in the initial vaginal DNA sample indicated there was male contact, however, due to the insufficient resident sample no further DNA testing could be completed.

During interview with the AP, he stated he did not sexually touch the resident.

When interviewed family stated they believed the AP raped the resident.

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: …
(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: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated the incident, made appropriate reports, required the AP remain on leave until law enforcement completed investigation. In addition, the facility provided two staff members for cares and female staff as able.

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
Roseville Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28965	A. BUILDING: _____ B. WING _____	C 05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIRA CHOICE ROSEVILLE	2996 CLEVELAND AVENUE NORTH ROSEVILLE, MN 55113

(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: #H289653261M, #HL289653364C On May 20, 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 81 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #H289653261M, #HL289653364C tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		