Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL291899565M
Compliance #: HL291897483C

Date Concluded: February 13, 2024

Name, Address, and County of Licensee Investigated:
The Legacy of Delano
1350 Saint Peter Street
Delano, MN 55328
Wright County

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

Evaluator's Name:
Jennifer Segal RN, Special Investigator
Jessica Sellner RN, Special Investigator

Finding: Substantiated, facility 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 facility neglected Resident #1(R1) and Resident #2 (R2) when they failed to provide the appropriate level of supervision when R1 and R2 had sexual contact.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility discovered R1 and R2 had sexual contact and assessed R1 was unable to consent to a sexual relationship related to R1's cognitive ability. R1's family requested R1 and R2 have no further sexual contact. The facility failed to ensure R1 and R2 were supervised, and interventions were implemented to prevent further sexual contact between R1 and R2. Approximately one month later, R1 and R2 were found in R1's apartment having another sexual encounter.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator coordinated with law enforcement. The investigation included review of resident's medical records, facility investigations, video monitoring, family and facility coordination's and facility policy and procedures. Also, the investigator observed staff and resident interactions at the facility during meals, activities, and personal cares.

Resident #1's medical record indicated R1 resided in an assisted living apartment with diagnoses including a cognitive impairment, short term memory loss, and impaired safety and judgment. R1's service plan included assistance with medication, meals, and laundry.

Resident #2 resided in an assisted living apartment with degenerative neurological diseases and experienced "brain fog" and other vulnerabilities. R2's service plan included assistance with meals, medication, and personal care.

R1 and R2's nursing notes indicated early one morning staff observed R2 leaving R1's apartment. Nursing staff investigated further, R1 stated no knowledge of a relationship or any sexual encounters. Nursing notes indicate R2 stated R1 and R2 had a sexual relationship when R2 was in R1's room.

The facility investigation indicated R1's family was concerned with R1's ability to consent to a sexual relationship and inquired what the facility could do to ensure R1 and R2 had no further sexual contact. The facility told R1's family they would implement two safety checks for R1 during the night. In addition, the facility made recommendations to R1's family for additional monitoring devices. The facility investigation indicated management staff spoke with R2 and implemented a verbal agreement that the relationship could not continue and R2 was told not to enter R1 apartment or call R1.

R1's progress note indicated approximately ten days later the resident's family placed a camera in R1's apartment and the facility discontinued R1's two safety checks.

A facility investigation indicated, approximately two weeks after the camera was installed the facility staff were contacted by R1's family who reported R2 was in R1's apartment and requested staff immediately go to R1's apartment and ask R2 to leave.

The recorded incident was reviewed and R1 was observed opening the apartment door and allowed R2 into the apartment. R1 and R2 were observed talking [inaudible], laughing, hugging, and kissing. After a couple minutes R1 and R2 walked into R1's bedroom and closed the door. Approximately five minutes later two staff were observed entering R1's apartment and proceeded to knock on R1's bedroom door.

During an interview a facility nurse stated R1 and R2 were both vulnerable, and a safety plan was intended to protect both residents.

During an interview a member of facility leadership stated R1 and R2 lived in close proximity, however the residents were not moved until after the second sexual encounter occurred.

During an interview a manager stated the facility did not do enough to prevent the incident from occurring a second time. The manager stated the facility had unrealistic expectations of R1 and R2's ability to follow through on the expectations of facility and family.

During an interview R2's family members stated they notified facility management of concerns and lack of boundaries regarding R1 and R2.

In conclusion, the Minnesota Department of Health determined neglect 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.
Vulnerable Adult interviewed: R1 yes, R2 yes
Family/Responsible Party interviewed: R1 yes, R2 yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility moved R2 to another area until R1 could move to a higher level of care/supervision.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

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
Wright County Attorney
Delano City Attorney
Delano Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29189	A. BUILDING: _____ B. WING _____	C 11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF DELANO	1350 ST. PETER AVENUE EAST DELANO, MN 55328

(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: #HL291897483C/ #HL291899565M On November 29, 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 52 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL291897483C/#HL291899565M, 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 two of two residents reviewed (R1, R2) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		