Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304346001M
Compliance #: HL304348680C

Date Concluded: January 21, 2025
Date Revised: February 4, 2025

Name, Address, and County of Licensee Investigated:
St. Ann's Residence
330 E. 3rd Street
Duluth, MN 55802
St. Louis County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Michele Larson, RN
Special Investigator
Revised By: Jill Hagen, RN, PHN, Rapid Response Supervisor

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), a facility staff member, sexually abused resident #1 when he had sex four or five times with the resident in his apartment**.** In addition, resident #2 reported she and the AP had consensual sex and drank alcohol together. In addition, the AP financially exploited resident #2 when he stole $74.00 from resident #2, making her fearful of the AP.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined sexual abuse was substantiated with resident #1 and resident #2. The AP was responsible for the maltreatment. Resident #1 told more than one licensed health care professional she had sex with the AP maintaining her story to both licensed professionals. The AP ~~who worked at the facility~~ was employed full time at the facility and also lived as an independent resident in a facility apartment, received no services and

denied having sex with resident #1 and stated resident #1 was in his apartment only once. However, facility video footage captured resident #1 entering the AP's apartment multiple times either with the AP or entering only after the AP let her in. Resident #2 told her case manager she and the AP had a sexual relationship and resident #2 was fearful of the AP. Resident #2 was vulnerable because she resided in an she assisted living facility. There was not a preponderance of evidence the AP stole money from Resident #2. ~~admitted to a consensual sexual relationship with the AP and lived as an independent resident in the facility and received no services, therefore, did not meet the criteria as a vulnerable adult under the Minnesota Vulnerable Adults Act.~~

The investigator conducted interviews with facility staff members, including facility leadership, the resident, and the AP. The investigator contacted the resident #1's licensed health care professionals. The investigation included review of the resident record, hospital record, the AP employee file, staff schedules, and related facility policy and procedures. The investigator reviewed the facility's video footage. Also, the investigator observed staff and resident interactions during an onsite investigation.

Resident #1 resided in an assisted living facility on the main floor of the facility. Resident #1's diagnoses included bipolar disorder, schizophrenia, and borderline personality disorder. Resident #1's service plan included assistance with medication management and administration. Resident #1 was non-compliant with her medications. The resident was at risk to be abused, used a cane and a walker for mobility, and was able to make her needs known.

Resident #2 resided in an assisted living facility. Resident #2's diagnoses included borderline personality disorder and Bipolar disorder with a history of abuse by another significant other.

The AP was hired to work in the facility four months before he moved in as an independent resident at the facility.

Review of facility time-stamped motion detection video footage of the AP's hallway (located on the lower level of the facility) revealed days and times the AP and resident #1 were together in the AP's apartment:

On the first day for the recorded video footage, at 12:40 a.m., the video showed the AP walking down the hallway and entering his apartment. Thirty minutes later at 1:11 a.m., resident #1 dressed in pajamas, walked with a cane in her right hand to the AP's apartment, knocked then lowered her arm to her side as she waited for the AP to open his apartment door. A moment later, the AP opened his door, and resident #1 entered his apartment. No motion was detected from the AP's hallway camera system until 1:46 a.m. when the AP and resident #1 walk towards the camera and elevators located out of camera view on the lower right-hand side of the screen.

The following day at 12:07 a.m., the video footage showed the AP walk down the hall and enter his apartment. At 12:33 a.m., resident #1 walked towards the AP's apartment wearing pajamas and carrying her cane in her left hand. The resident knocked on the AP's apartment door. The AP immediately opened his door and resident #1 walked in. No motion was detected from the hallway camera until 1:50 a.m. when both resident #1 and the AP were seen walking down the hallway together towards the elevators.

Two days later at 3:48 a.m., the video footage showed resident #1 walk down the AP's hallway wearing pajamas, stopping at the AP's apartment door, and knocking on the AP's apartment door. Resident #1 appeared to speak to the AP before the video clip ended as resident #1 entered the AP's apartment. No motion was detected from the AP's hallway camera until 3:56 a.m. when the AP was seen walking without shoes down the hallway towards the camera. At 3:57 a.m., the AP reappeared walking back to his apartment carrying a glass in one hand and an unidentified object in the other hand. No motion was detected from the AP's hallway camera until 4:44 a.m. when resident #1 walked away from the AP's apartment towards the elevators.

One day later at 2:15 a.m., the recorded video footage showed resident #1 appear on camera wearing short pajamas and a matching top using her walker as she walked towards the AP's apartment. The AP suddenly appeared on video walking up from behind resident #1 pulling his apartment keys out of his right pocket. The AP unlocked his apartment door, and he and resident #1 entered his apartment. No motion was detected from the AP's hallway camera system until 3:54 a.m. when resident #1 was shown walking away from the AP's apartment towards the elevators.

Three days later at 2:46 a.m., the recorded video footage showed resident #1 walking the hallway using her walker towards the AP's apartment. Resident #1 was barefoot and wore a short pajama set. The resident stopped, knocked once, then entered the AP's apartment. No motion was detected on the AP's hallway camera system until 3:59 a.m. when resident #1 was seen walking down hallway towards the elevators.

Review of the facility internal investigation indicated resident #1 told leadership she had sex in the AP's room but stated it was only one time and stated the sex was consensual. The report indicated resident #1 repeated several times that she did not understand why resident #2 would date the AP knowing she had sex with the AP.

Review of the AP's employee file indicated the AP received training on both maintaining professional boundaries with residents and vulnerable adults.

During a phone call, resident #2 stated resident #1 and her family member were mentally ill.

When interviewed, leadership stated resident #1 came from an abusive relationship and previously resided at a battered women's shelter prior to moving into the facility. Although leadership admitted resident #1 was a vulnerable adult with multiple mental health diagnoses,

leadership stated it was resident #1 who aggressively pursued the AP, pounding on the AP's door in the middle of the night. Leadership stated the AP told them he never let resident #1 into his apartment except one time to watch a television show sometime after an evening meal. Leadership stated they received a note and had a conversation with resident #2 that she had a sexual relationship with the AP. Leadership stated it was an odd coincidence to have resident #1 and resident #2 have similar allegations against the AP.

When interviewed, resident #1's health practitioner stated she was concerned when resident #1 told the practitioner, she and the AP were having sex in the AP's apartment on several occasions. The health practitioner stated it was inappropriate since the AP worked at the facility. Resident #1's health practitioner stated the resident was "pretty lucid and with it," when resident #1 told her about having sex with the AP and the practitioner suspected no false reporting from resident #1.

When interviewed, resident #2's case manager stated resident #2 wrote a letter to the management at the facility informing them of a sexual relationship between resident #2 and the AP.

When interviewed, resident #1's case manager stated it was at their first meeting when resident #1 told him she did "sexual things" with the AP. The case manager stated he found out the AP both worked and resided at the facility. Resident #1's case manager stated the resident told him she realized she made a mistake and should not have had sex with the AP, stating she also told her family member who became upset and told resident #1 she should leave the facility. The case manager stated, "Resident #1 pretty much knew she shouldn't have done that; and that was why she was telling others about it." The case manager stated the resident was "very" believable.

When interviewed, resident #1 stated she and the AP had sex one time stating, "he gave me a beer and seduced me." Resident #1 stated she and the AP saw each other for a few weeks, stating it was usually around 2:00 a.m. after he returned from the bars. Resident #1 stated, "He was on to me and flirted with me." Resident #1 stated she never agreed to a relationship with the AP stating, "It just happened."

When interviewed, the AP denied he ever had sex with resident #1 stating, "There was no incident whatsoever, absolutely none stating, I wouldn't come within ten feet of her!" The AP stated resident #1 was "really pushy" about watching a television show, stating his apartment door was open when resident #1 walked by one evening around 7:00 p.m. The AP said resident #1 "put him on the spot," so the AP found the television show for resident #1. The AP stated he gave resident #1 "pop" and popcorn as they watched her show, stating his apartment door was wide open the entire time. The AP stated resident #1 left his apartment when the show was done. The AP stated after that one time he knew he would not be doing that again stating, "She is kind of crazy to be straight honest with you." The AP stated two weeks prior he heard from co-workers that resident #1 had a "crush" on him and was infatuated with him stating, "one

staff told me resident #1 said we were dating, stating he told resident #1 to stop that “crazy talk.” The AP stated he knows he should not have done it stating he knows he did nothing wrong but only wished his apartment door had been closed. The AP stated he was being accused of something he did not do, stating resident #1 was a “dangerous” person. The AP stated he dated resident #2.

In conclusion, the Minnesota Department of Health determined sexual 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:
(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; or
(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 unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(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: Yes.

Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation.

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.

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

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
St. Louis County Attorney
Duluth City Attorney
Duluth Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30434	A. BUILDING: _____ B. WING _____	C 12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANN'S HOME	330 EAST 3RD STREET DULUTH, MN 55805

(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, this correction order 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: #HL304348680C/#HL304346001M On December 18, 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 51 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL304348680C/#HL304346001M, 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANN'S HOME	330 EAST 3RD STREET DULUTH, MN 55805

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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		