DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305572346M
Compliance #: HL305571607C

Date Concluded: April 12, 2024

Name, Address, and County of Licensee Investigated:
White Bear Lake White Pine
1235 Gun Club Rd
White Bear Lake, MN 55110
Ramsey County

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

Evaluator's Name: Deb Schillinger RN, Special Investigator
Paul Spencer, RN
Special 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) abused the resident when the AP engaged in a sexual act with the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. An unlicensed caregiver witnessed the AP engage in a sexual act with the AP standing in front of the resident, who was seated on her bed, with his pants undone and his hands placed on the resident's shoulders. The unlicensed caregiver saw the resident moving her head suggestive of performing oral sex. The resident wiped her mouth after separating from the AP when the unlicensed caregiver interrupted.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and the resident's family. The investigator contacted law enforcement. The investigation included review of the resident's medical records, incident report and internal investigation notes, the AP's personnel file, and facility related policy and procedures. Also, the investigator observed the resident and facility staff interactions and the resident's living space.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Parkinson's disease, dementia, and anxiety. The resident's service plan included assistance with cueing and reminders to complete tasks. The service plan included a scheduled toileting and safety checks every two hours, which included a safety check scheduled for 10 a.m. The resident's assessment indicated the resident was non-English speaking, disoriented, lacked the ability to use a call light, and was able to walk with a walker.

The facility's internal investigation report indicated unlicensed caregiver #1 walked into the resident's room and witnessed the resident making head movements suggesting she was engaged in performing oral sex on the AP. Additionally, the report indicated unlicensed caregiver #1 stated the AP's pants were both unbuttoned and unzipped, and unlicensed caregiver #1 alerted administrative staff members.

The same internal investigation report contained photos of the resident's room, showing the resident's bed with indentation indicating someone was sitting on the edge of the bed and a folding chair in front of the indentation on the bed. The description of the photos indicated they were taken at the angle(s) described from unlicensed caregiver #1 vantage point when she found the AP and the resident as she described it to administration of the facility.

The same internal investigation included an interview of the AP. The notes indicated the AP said he asked the resident if she wanted to nap, the resident said yes, and the AP walked her to her room. The AP said he was trying to scoot the resident back after he sat her on the bed when unlicensed caregiver #1 entered the room. The AP said he sat down in the chair next to the bed and unlicensed caregiver #1 said "I know what you are doing in here and I am going to go tell somebody." The AP said he was in the room with the resident less than one minute, probably closer to 30 seconds before unlicensed caregiver #1 walked in.

Unlicensed caregiver #1 provided a written statement at the time of the incident which indicated she was checking her scheduled tasks at her medication cart after her morning break, when she looked down the hall and saw the AP redirecting another resident away from the resident's apartment door. After finishing at the medication cart, unlicensed caregiver #1 walked down the hall, saw the other resident at the end of the hall but did not see the resident and AP. She noticed the resident's door partially open and stepped inside the room to check to see if the resident needed toileting. Unlicensed caregiver #1 reported she saw the resident sitting on the bed with the AP standing in front of the resident. Unlicensed caregiver #1 stated

she walked further into the room and saw the AP's pants were unzipped and unbuttoned, the AP's hands were placed on each shoulder of the resident, and the resident's head was moving in a way suggesting oral sex was being performed. Unlicensed caregiver #1 saw the resident pull back from the AP's private area and wipe her mouth, as the AP gave a pat on the resident's left shoulder. Unlicensed caregiver #1 wrote she interrupted by saying "what are you doing!" which startled the AP who was trying to zip and button his pants, but she proceeded to walk towards the AP, and he sat down on the chair behind him where his pants remained unbuttoned and unzipped. Unlicensed caregiver #1's statement indicated she left the room after saying she was going to tell someone, and saw the housekeeper was in the hallway when unlicensed caregiver #1 left the resident's room.

During an interview, unlicensed caregiver #1 described the incident, including showing the investigator the resident's room to demonstrate where all the parties were positioned during the incident. Unlicensed caregiver #1 stated she did not see the AP's penis when he was standing in front of the resident due to the AP's clothing restricting her line of sight. After unlicensed caregiver #1 started questioning the AP on what he was doing, he sat down in the chair and covered himself. The AP stated he was showing the resident something on his phone, but she did not see the AP's phone. She left the room to notify administration staff members of what she observed, saw the housekeeper in the hall, and the AP followed after her shortly. Unlicensed caregiver #1 stated the AP was alone with the resident between five to 10 minutes.

During an interview with the housekeeper, she stated she saw unlicensed caregiver #1, in the opposite hallway near the resident's room, appeared distraught and crying. While she asked unlicensed caregiver #1 what was wrong, the AP came out of the resident's room directly towards her, stating "What did she tell you? I didn't do anything". The housekeeper stated the AP's face was red, appeared to be upset and was adjusting the waistband of his pants. After the housekeeper declined to respond, the AP walked down the hall at a fast pace towards the stairway. The housekeeper stated she had witnessed the AP walking in the hallways with the resident earlier the same morning.

During an interview, the AP stated he helped out with cares at the facility because of poor cares provided by some of the aids, which is why he was walking with the AP. The AP said on the day of the incident he had been walking in the hallway with the resident when an aide at the medication cart [later identified as unlicensed caregiver #2] said the resident was probably going to want to take a nap, the AP then asked the aide if she wanted him to put the resident down for a nap, and she asked him to do so. The AP stated he used Google translator on his phone to offer the resident a nap, she agreed, he then took the resident to her room, and sat the resident on the edge of the bed. Upon trying to pivot the resident into the bed, the resident leaned her head forward hitting his waist area. The AP stated he was trying to "scoot" the resident back in the bed when unlicensed caregiver #1 came into the room and started addressing him in an accusatory tone. The AP denied his pants were open, unbuttoned and/or unzipped stating he would remember if he needed to pull up his zipper but did not remember doing so. The AP also stated he was wearing dress slacks with suspenders and there was an

ongoing issue with zipper being down without him realizing it. The AP said unlicensed caregiver #1 could not have seen if his pants were unzipped as he had his back to her. The AP stated he helped with cares a lot because the care was not of the highest quality, and he did not do anything inappropriate with the resident.

A review of the documents regarding the incident and the facility's staffing schedule indicated three employees besides the AP, who was not a direct caregiver, working in the secured dementia unit when this event occurred. Those three employees were the housekeeper, unlicensed caregiver #1, and unlicensed caregiver #2. Unlicensed caregiver #2 was identified as the person the AP referred as she matched the AP's description and was the only other caregiver working in the area on the shift. The facility's internal document notes also indicated the AP identified the unlicensed caregiver #2 by first name.

During an interview, unlicensed caregiver #2 stated she had not asked the AP to provide patient cares on this day or any other day.

A review of the AP's personnel file did not identify documentation indicating the facility provided the AP training as a caregiver nor did his job description indicated providing cares was included in his role.

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:
(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:
(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 resident is cognitively impaired.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
An internal investigation was completed, and the AP was suspended during investigation.

Action taken by the Minnesota Department of Health:
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

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
Ramsey County Attorney
White Bear Lake City Attorney
White Bear Lake Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30557	A. BUILDING: _____ B. WING _____	C 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE BEAR LAKE WHITE PINE	1235 GUN CLUB ROAD WHITE BEAR LAKE, MN 55110

(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****** HOME CARE PROVIDER/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: On March 19, 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 33 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued that were not issued at the time of immediate correction orders. The following correction order is issued/orders are issued for #HL305571607C/#HL305572346M, tag identification 0630 and 2360.	0 000	Minnesota Department of Health is documenting the State 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. 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 SUBDIVISION 1-3.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to update one-of-one resident reviewed (R1) individual abuse prevention plan (IAPP) along with specific measures for R1 reported possible sexual abuse. Additionally, no specific training nor education was provided to facility staff after the incident was reported. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on June 20, 2023, with diagnoses including Parkinson's disease, dementia, and anxiety. R1's comprehensive assessment dated January	0 630		

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0 630	Continued From page 2 31, 2024, indicated R1 spoke Polish primarily and limited words in English, as a result R1 was not always able to make herself understood. R1's Vulnerable Adult/Individual Abuse Prevention Assessment dated January 31, 2024, indicated R1 was at risk for abuse including sexual abuse. The interventions listed included for staff to monitor to signs and symptoms of abuse and report possible abuse to supervisors immediately. An incident report dated February 29, 2024, indicated possible abuse occurred and described as forced oral sex upon R1 by a facility employee (FE)-H. The facility's subsequent internal investigation indicated an unlicensed personnel (ULP)-F entered R1's and saw R1 moving her head in a way suggestive of oral sex with FE-H standing by her and his pants zipper down. A progress note dated March1, 2024, titled "Assessment" indicated registered nurse (RN)-G observed R1 the next morning doing her "usual routine". The progress notes indicated R1's vital signs were checked, her lung sounds were clear, and her bowel sounds active. A review of R1's medical record and the facility's internal investigation did not identify documentation that law enforcement was called, or a sexual assault nurse examiner (SANE) was offered. Email correspondence with the facility dated March 26, 2024, indicated R1's medical provider was not notified. The same document indicated R1's IAPP had not been updated since January 31, 2024. During an interview, the RN-G stated a partial	0 630		

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0 630	Continued From page 3 assessment was completed and documented in R1's progress notes. RN-G stated no additional training was provided to facility staff as the yearly vulnerable adult training was sufficient. The licensee-provided policy titled "Individual Abuse Prevention Plan" dated March 07, 2023, indicated the IAPP will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. The licensee provided IAPP sample assessment indicated the IAPP should be updated initially (on admission), at the 14-day and 90-day assessments and with a change of condition. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. The 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	02360	No plan of correction required for tag 2360. Please refer to the public maltreatment report for details.	

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02360	Continued From page 4 occurred at the facility. Please refer to the public maltreatment report for details.	02360		