Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306721821M
Compliance #: HL306729623C

Date Concluded: April 23, 2024

Name, Address, and County of Licensee Investigated:
Sunlight Senior Living
400 Western Avenue
St Paul, MN, 55103
Ramsey County

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

Evaluator's Name: Jennifer Segal RN, BSN
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), facility staff, abused the resident when the AP removed the residents clothing down to undergarments and touched the resident's breasts.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The resident demonstrated with body language and hand gestures the AP touched the residents' breasts. The AP's DNA matched the male DNA found on the residents' breasts. The AP was charged with 4th degree criminal sexual conduct.

The investigator interviewed facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the case manager. The investigation included a review of the resident's facility record, hospital records, facility internal investigation, video footage of the common area, employee records, and pertinent facility

policy and procedures. Also, the investigator observed staff and resident interactions and care provided at the facility.

The resident resided in an assisted living memory care unit with diagnoses including deafness and neurodevelopmental disorder. The resident's assessment indicated cognition could not be assessed because the resident could not communicate needs or understand others. The resident walked independently and enjoyed socializing with others. The resident's service plan included safety, supervision, assistance with personal care when needed, and additional heavy housekeeping as needed.

A facility investigation indicated one afternoon; facility staff observed the resident gesture signs they believed might indicate someone touched the resident in a sexual manner. The staff indicated the resident pointed at the AP and appeared fearful and agitated when the AP was nearby. Management assessed the resident, and the resident put both middle fingers up, nodded her head, made a fist with her right hand, and covered her mouth. In addition, the resident rubbed her breasts and then rubbed the staff's breasts. Facility staff indicated the gestures were unusual for the resident, and staff called 911.

A hospital note indicated interpreters could not communicate with the resident, and the resident appeared to use nonstandard sign language.

A hospital examination note indicated the resident communicated to the family a man had removed layers of clothing down to her undergarments. The resident gestured a letter L with her thumb and forefinger in front of nose, which family confirmed the resident was gesturing it was a man. The resident was wearing four layers of clothing at the hospital and demonstrated peeling all four layers of clothing off. The family asked if the male touched her breasts, and the resident touched her breasts and nodded yes. The family made a circle with the thumb and forefinger of one hand and put the other forefinger through the circle to ask if there was penetration. The resident touched her cheek with a forefinger up and down, a gesture of shame and embarrassment, and shook her head no. The exam included additional forensic specimens, including skin swabs of the resident's left and right breasts for touch DNA and blood work.

A facility document indicated management interviewed the AP, and the AP denied touching the resident. The facility determined due to uncertainty of the allegation and the resident’s response the AP could not return to work until law enforcement finished the investigation.

Recorded video footage of the hallway outside the resident’s room was observed and showed the AP knock on the resident's door and enter the apartment for less than 45 seconds on several occasions throughout the shift. The AP was observed knocking on the resident’s door before walking in and carrying supplies for work and removing items following clean up.

During interview, facility leadership stated the resident had never made sexual hand gestures or appeared fearful of the AP until the day of the incident.

During interview a staff stated suddenly one day the resident was scared and reacted negatively when the AP was in sight. The staff stated the resident spent most of the time outside of the apartment and enjoyed socializing, however, the morning of the incident the resident did not come out for meal as usual. The staff stated the resident had additional vulnerability for abuse because she wanted to please others, did not understand physical boundaries, and had limited communication including deafness.

During interview a family member stated the resident clearly communicated through her own sign to family that a man was in her apartment and the resident story was consistent throughout the day and night. The family stated the resident had never expressed a sexual gesture or accused anyone of touching her inappropriately in past.

During interview the AP denied touching the resident sexually and stated he had no reason to touch the resident as he did not assist with resident cares.

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:
(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.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility called 911 and investigated the incident.

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
St Paul Police Department
Ramsey County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30672	A. BUILDING: _____ B. WING _____	C 02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNLIGHT SENIOR LIVING	400 WESTERN AVENUE SAINT PAUL, MN 55103

(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 On February 13, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL306721821M, #HL306729623C No correction orders are issued.	0 000		