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 #: HL312723160M
Compliance #: HL312723123C

Date Concluded: August 13, 2024

Name, Address, and County of Licensee Investigated:
Croixdale
850 Highway 95 North
Bayport, MN 55003
Washington County

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

Evaluator's Name: Jennifer Segal RN, BSN
Special Investigator

Finding: Not Substantiated

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, financially exploited the resident when the resident inquired with facility staff how to add the AP to lease agreement. In addition, the AP sexually abused the resident when the AP and resident kissed and began a personal relationship.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse and financial exploitation was not substantiated. The resident requested the facility allow the resident to add the AP to the new lease agreement. The facility did not agree to the resident's request and took action to protect the resident. Although the AP and resident shared a relationship it did not meet the definition of sexual abuse.

The investigator conducted interviews with facility staff members. The investigation included review of the resident's facility record, facility internal investigation, personnel files, staff schedules and related facility policies and procedures. Also, the investigator observed other staff and resident interactions.

The resident resided in an assisted living facility with diagnoses including quadriparesis (weakness in legs and arms). The resident's service plan included assistance with housekeeping and meals. The resident's assessment indicated he had no cognitive impairment, was his own decision-maker, and was independent with personal needs.

One month after the resident's admission, a meeting was arranged to review the resident's care and services. The resident expressed a desire to move to an independent living apartment within the same community, as they believed they did not require or receive any personal care services from assisted living. The resident was placed on a waitlist for independent living and later decided to move when an apartment became available.

Two days prior to the resident's move from assisted living to independent living, the resident inquired about adding an occupant, the AP, to the new lease agreement. The facility investigated the relationship between the resident and the AP. The resident stated the relationship was not romantic, they [the AP and resident] were good friends, and the resident wanted to live with the AP.

The facility's internal investigation indicated facility leadership met with the AP, and the AP acknowledged a relationship with the resident. The AP was placed on administrative leave and asked not to visit the community. Later, the AP resigned and stated the relationship was more important than the job.

During an interview, facility leadership stated the facility policy prohibited staff members from personal relationships with residents, regardless of the resident residing in assisted living or independent living, a staff member cannot become a second occupant or sign a resident lease agreement. The resident disagreed with the facility decision not to allow the AP to join the residents lease agreement and decided to move out of the facility and return to his previous home.

During an interview, the resident stated there was no problem with the AP and no coercion. He stated the facility did not handle the situation well, and he felt terrible for the AP. He believed it shouldn't have reached this point, as nothing was going on, and he lived independently.

In conclusion, the Minnesota Department of Health determined abuse and financial exploitation was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

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;
(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.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:

(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or
(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Not applicable.
Alleged Perpetrator interviewed: No, did not respond to requests.

Action taken by facility:
The facility investigated the incident, made required reports, and took steps to ensure the resident’s safety.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31272	A. BUILDING: ____ B. WING ____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROIXDALE	**850 HIGHWAY 95 NORTH BAYPORT, MN 55003**

(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 June 13, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL312723160M/#HL312723123C. No correction orders are issued.	0 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE