

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL334172682M  
**Compliance #:** HL334174514C

**Date Concluded:** September 8, 2023

**Name, Address, and County of Licensee**

**Investigated:**

Sanctuary Healthcare Services  
1623 Silver Lane  
New Brighton, MN 55112  
Ramsey County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Brooke Anderson, RN  
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):**

A facility staff member/alleged perpetrator (AP) abused a resident when the AP text the resident after work hours, took the resident to the store, and touched the resident on the waist when the resident was trying on clothes.

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined abuse was not substantiated. Although the alleged perpetrator's (AP) actions were inappropriate and unprofessional, there was not a preponderance of evidence they met the definition of abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's case worker. The investigation included review of the resident's medical record, personnel files, facility policies and procedures, and text messages exchanged between the AP and the resident. In

addition, at the time of the onsite visit, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included major depressive disorder with psychotic features and generalized anxiety disorder. The resident's assessment included assistance with medication management and behavioral support. The resident's assessment further indicated the resident was alert, orientated, provided information accurately, and was able to report abuse.

A review of text messages identified communication occurred between the resident and the AP over a period of several months. The AP and resident communicated via personal cell phones. The text messages identified communication occurred when the AP was not on shift at the facility. The text messages included the AP texting the resident "let me come check on you" and "are you in bed?" In the text message communication, the AP called the resident beautiful, complimented her hair, and asked how her clothes looked on her.

During an interview, the resident stated the AP was nice but made her feel uncomfortable. The resident stated there were times when the AP would look at her for a long time and say things like, "you know I care about you." An incident occurred when the resident was in her room trying on new clothes and the AP came in and put her hands on the resident's waist and said, "you look good." The resident stated another incident occurred when the resident and AP were on a walk. The AP stated, "can I ask you a question?" The resident told the AP, "No" because she knew where the conversation was going. The resident stated there were additional instances where the AP made her feel uncomfortable. The AP would massage the resident's hand when checking the resident's blood pressure, volunteer to drive the resident to the store, hang out at the facility while not scheduled, and asked the resident to get a place to live with the AP. The resident stated when she told the AP to stop, the AP just laughed. The resident stated she reported to a facility staff member about the AP's texts and that she was uncomfortable.

During an interview, the AP stated she had received training on abuse prevention and vulnerable adults. The AP stated she did not want a relationship with any of the residents at the facility but liked to talk and joke with them. The AP stated she brought residents to the store when they asked her to, even when she was not "on the clock." The AP stated the resident was depressed so she asked the resident how she was doing. The AP stated the resident sent her a picture of her hair and the AP responded via text with, "it looks good on you." The AP acknowledged there had been text message communication between herself and the resident that were not work related.

During an interview, a facility staff member recalled the resident telling her about the AP's text messages, that it made the resident uncomfortable, and the resident thought it was creepy. The staff member said she read through the text messages and saw "do you want to be my girlfriend?" in a text from the AP to the resident. The staff member stated it was not uncommon

of the AP to come to the facility to rest and eat food in between jobs. The facility staff member stated the AP volunteered to take female residents to the store. The staff member stated she did not report what the resident told her about the AP to management because she did not think it was serious and thought the AP was joking.

During an interview, the resident's case worker stated the resident was a very passive person and the resident's anxiety would get bad during social interactions. The case worker stated the resident reported via a phone conversation, that the AP was overly friendly with her. The resident reported a time when the AP came into her room while she was trying on new clothes. The AP told the resident the clothes looked good and touched the resident's waist. The case worker stated the resident reported the AP wanted to be friends on social media, but it made the resident feel uncomfortable. The case worker stated she attempted to obtain more information from the resident regarding the AP, but the resident was very hesitant, quiet, and did not want to discuss it further. The resident told the case worker she wanted to move out of the facility due to the actions of the AP.

During an interview, facility management described the resident as reserved and calm. Facility management stated they were not aware of the AP making the resident uncomfortable. Facility management stated the facility required and provided training on boundaries and vulnerable adult training. The facility management stated they were unsure why the AP was at the facility when not scheduled to work. Facility management stated they had a list of resident personal cell phone numbers at the facility. Staff were directed to utilize their [the staff's] personal cell phones to contact a resident if the resident was on a leave of absence or to check on the resident. Facility management acknowledged this may be how the AP obtained the resident's cell phone number.

In conclusion, the Minnesota Department of Health determined abuse 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;

**Vulnerable Adult interviewed:** Yes.

**Family/Responsible Party interviewed:** No. Declined to be interviewed.

**Alleged Perpetrator interviewed:** Yes.

**Action taken by facility:**

The facility completed an investigation, suspended the AP, and implemented education for facility staff. The facility also purchased a facility phone to text and call residents on during a leave of absence, in place of the staff using their personal cell phones.

**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

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:  <b>33417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/01/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SANCTUARY HEALTHCARE SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1623 SILVER LANE NEW BRIGHTON, MN 55112</b>
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0 000	<p><b>Initial Comments</b></p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b> HL334172682M/HL334174514C HL334177510M/HL334174100C</p> <p>On August 1, 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 four residents receiving services under the provider's Assisted Living license.</p> <p>No correction orders were issued for complaint #HL334177510M/HL334174100C.</p> <p>The following correction orders are issued for HL334172682M/HL334174514C, tag identification 0620, 2410, and 3000.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL</p>	

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 620 SS=G	<p><b>144G.42 Subd. 6 (a) Compliance with requirements for reporting ma</b></p> <p>(a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R1), with records reviewed.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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).</p> <p>The findings include:</p> <p>R1 was admitted to the licensee on December 27, 2022, with diagnoses which included major depressive disorder with psychotic features, and generalized anxiety disorder.</p> <p>R1's undated 24hr customized living assessment</p>	0 620		

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0 620	<p>Continued From page 2</p> <p>included assistance with medication management, and behavioral support.</p> <p>R1's nursing assessment dated January 11, 2023, indicated R1 was alert, oriented, and needed staff assistance with medication administration.</p> <p>R1's individual abuse prevention plan (IAPP) dated January 24, 2023, indicated R1 was able to report abuse or neglect and was able to accurately provide information.</p> <p>Unlicensed personnel (ULP)-C's employee records indicated ULP-C received abuse prevention and vulnerable adult training.</p> <p>ULP-E's employee records indicated ULP-E received abuse prevention and vulnerable adult training.</p> <p>A review of R1's text messages dated May 11, 2023, at 9:15 p.m. indicated ULP-C text R1, "What are you doing?" R1's text messages at 9:24 p.m. indicated ULP-C text R1 "let me come check on you." R1's text messages at 10:58 p.m. indicated ULP-C text R1 "are you in bed?"</p> <p>R1's text messages dated July 1, 2023, at 2:33 p.m. indicated ULP-C text R1 after R1 sent ULP-C a picture of her hair. ULP-C replied with, "beautiful." R1's text messages at 2:34 p.m. indicated, "look[s] good on you." R1's text messages at 4:41 p.m. indicated ULP-C text R1 "how does the clothes looks on you?"</p> <p>R1's text messages dated July 2, 2023, at 6:27 p.m. indicated ULP-C text R1, "do you wanna go for a walk?"</p>	0 620		

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0 620	<p>Continued From page 3</p> <p>During observation ULP-C was at the facility and provided facility tour but ULP-C not scheduled and left the facility after the investigator arrived.</p> <p>During an interview with R1 on August 1, 2023, at 11:15 a.m., R1 stated ULP-C said things that made R1 feel uncomfortable. R1 stated ULP-C stated, "you know I care about you." R1 stated when R1 was trying on new clothes ULP-C came in her room and told her, "You look good," and put his hands on her waist. R1 stated ULP-C asked R1 if she wanted to get a place to live with ULP-C. R1 stated when ULP-C checks R1's blood pressure ULP-C massages R1's hands. R1 stated she did ask ULP-C to stop and ULP-C would just laugh. R1 repeatedly stated ULP-C made her uncomfortable. R1 stated she told someone at the facility about how ULP-C made her feel uncomfortable.</p> <p>During an interview with ULP-E on August 3, 2023, at 11:17 a.m., ULP-E stated R1 told her that ULP-C had been texting R1 and making her feel uncomfortable and R1 thought it was creepy. ULP-E stated she saw a text message on R1's phone that indicated, "do you want to be my girlfriend?" ULP-E stated ULP-C would come to the facility in between jobs and rest and eat. ULP-E stated ULP-C would volunteer to take the female residents to the store. ULP-E stated she did not report R1's concern to management because she didn't take it seriously and thought ULP-C was joking.</p> <p>During an interview with case manager (CM)-F stated R1 reported ULP-C felt uncomfortable and wanted to look for a new place to live.</p> <p>During an interview with licensed assisted living director (LALD)-A and licensed practical nurse</p>	0 620		

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0 620	<p>Continued From page 4</p> <p>(LPN)-B on August 1, 2023, at 10:14 a.m., LALD-A stated she was unsure why ULP-C was at the facility when he wasn't scheduled to work. LALD-A called ULP-C and ULP-C stated he was picking his food from the facility. LALD-A stated resident concerns would be reported to the nurses or LALD. The LALD-A stated, an investigation would be completed and action would be taken appropriately including reporting to the Minnesota Department of Health.</p> <p>The licensee's policy Vulnerable Adult dated March 28, 2017, indicated all caregivers who have knowledge of the abuse or neglect of a vulnerable adult or have reasonable cause to believe that a vulnerable adult is being or has been abused or neglected must report to the Administrator or Director of Nursing immediately.</p> <p>No further information provided.</p> <p>Time period for correction: Seven (7) days</p>	0 620		
02410 SS=D	<p><b>144G.91 Subd. 13 Personal and treatment privacy</b></p> <p>(a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan.</p> <p>(b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted</p>	02410		

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02410	<p>Continued From page 5</p> <p>in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan.</p> <p>(c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the resident's right to consideration of their privacy and personal property for two of two residents (R1, R2) with records reviewed. Rights to consideration of privacy and personal property were violated when staff text the resident (R1) and searched through the resident's (R1) belongings without consent and failed to knock on a door and ask permission before entering a resident's (R2) room.</p> <p>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).</p> <p>The findings include:</p> <p>R1 R1 was admitted to the licensee on December 27, 2022, with diagnoses which included major</p>	02410		

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02410	<p>Continued From page 6</p> <p>depressive disorder with psychotic features, and generalized anxiety disorder.</p> <p>R1's text messages dated May 11, 2023, at 9:15 p.m. indicated ULP-C text R1, "What are you doing?" R1's text messages at 9:24 p.m. indicated ULP-C text R1 "let me come check on you." R1's text messages at 10:58 p.m. indicated ULP-C text R1 "are you in bed?"</p> <p>R1's text messages dated July 1, 2023, at 2:33 p.m. indicated ULP-C text R1 after R1 sent ULP-C a picture of her hair. ULP-C replied with, "beautiful." R1's text messages at 2:34 p.m. indicated, "look[s] good on you." R1's text messages at 4:41 p.m. indicated ULP-C text R1 "how does the clothes looks on you?"</p> <p>R1's text messages date July 2, 2023, at 6:27 p.m. indicated ULP-C text R1, "do you wanna go for a walk?"</p> <p>During an interview on June 8, 2023, at 11:15 a.m., R1 stated ULP-C lost her phone and thought R1 took it. R1 stated ULP-C went through R1's belongings looking for ULP-C's phone without R1's consent.</p> <p>R2 R2 was admitted to the licensee on June 15, 2021, with diagnoses which included bipolar disorder, paranoid schizophrenia, and hyperprolactinemia.</p> <p>During an observation the investigator arrived at the facility and ULP-C was present. Schedule review indicated ULP-C was not scheduled to work the day of the onsite visit. The investigator observed ULP-C open R2's room door without knocking. When ULP-C opened the door, R2 was</p>	02410		

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02410	<p>Continued From page 7</p> <p>sitting on her bed just waking up.</p> <p>During an interview on August 1, 2023, at 10:14 a.m., licensed assisted living director (LALD)-A stated education is provided to staff to knock two to three times prior to entering a resident's room and ask permission to enter. The LALD stated all staff receive training on boundaries with residents. LALD stated when a resident goes out into the community, staff will text or call them to ensure their safety, but communication should occur during work hours.</p> <p>The licensee's Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, indicated, residents have the right to have personal, financial, health and medical information kept private. The residents have the right to consideration of their privacy. Staff must respect the privacy by knocking on the door and seeking consent before entering.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	02410		
03000 SS=G	<p>626.557 Subd. 3 Timing of report</p> <p>(a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the</p>	03000		

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03000	<p>Continued From page 8</p> <p>individual that occurred prior to admission, unless:</p> <p>(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or</p> <p>(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4).</p> <p>(b) A person not required to report under the provisions of this section may voluntarily report as described above.</p> <p>(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.</p> <p>(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.</p> <p>(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.</p>	03000		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>33417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/01/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SANCTUARY HEALTHCARE SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1623 SILVER LANE NEW BRIGHTON, MN 55112</b>
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03000	<p>Continued From page 9</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R1), with records reviewed.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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).</p> <p>The findings include:</p> <p>R1 was admitted to the licensee on December 27, 2022, with diagnoses which included major depressive disorder with psychotic features, and generalized anxiety disorder.</p> <p>R1's undated 24hr customized living assessment included assistance with medication management, and behavioral support.</p> <p>R1's nursing assessment dated January 11, 2023, indicated R1 was alert, oriented, and needed staff assistance with medication administration.</p> <p>R1's individual abuse prevention plan (IAPP) dated January 24, 2023, indicated R1 was able to report abuse or neglect and was able to accurately provide information.</p> <p>Unlicensed personnel (ULP)-C's employee</p>	03000		

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03000	<p>Continued From page 10</p> <p>records indicated ULP-C received abuse prevention and vulnerable adult training.</p> <p>ULP-E's employee records indicated ULP-E received abuse prevention and vulnerable adult training.</p> <p>A review of R1's text messages dated May 11, 2023, at 9:15 p.m. indicated ULP-C text R1, "What are you doing?" R1's text messages at 9:24 p.m. indicated ULP-C text R1 "let me come check on you." R1's text messages at 10:58 p.m. indicated ULP-C text R1 "are you in bed?"</p> <p>R1's text messages dated July 1, 2023, at 2:33 p.m. indicated ULP-C text R1 after R1 sent ULP-C a picture of her hair. ULP-C replied with, "beautiful." R1's text messages at 2:34 p.m. indicated, "look[s] good on you." R1's text messages at 4:41 p.m. indicated ULP-C text R1 "how does the clothes looks on you?"</p> <p>R1's text messages dated July 2, 2023, at 6:27 p.m. indicated ULP-C text R1, "do you wanna go for a walk?"</p> <p>During observation ULP-C was at the facility and provided facility tour but ULP-C not scheduled and left the facility after the investigator arrived.</p> <p>During an interview with R1 on August 1, 2023, at 11:15 a.m., R1 stated ULP-C said things that made R1 feel uncomfortable. R1 stated ULP-C stated, "you know I care about you." R1 stated when R1 was trying on new clothes ULP-C came in her room and told her, "You look good," and put his hands on her waist. R1 stated ULP-C asked R1 if she wanted to get a place to live with ULP-C. R1 stated when ULP-C checks R1's blood pressure ULP-C massages R1's hands. R1</p>	03000		

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03000	<p>Continued From page 11</p> <p>stated she did ask ULP-C to stop and ULP-C would just laugh. R1 repeatedly stated ULP-C made her uncomfortable. R1 stated she told someone at the facility about how ULP-C made her feel uncomfortable.</p> <p>During an interview with ULP-E on August 3, 2023, at 11:17 a.m., ULP-E stated R1 told her that ULP-C had been texting R1 and making her feel uncomfortable and R1 thought it was creepy. ULP-E stated she saw a text message on R1's phone that indicated, "do you want to be my girlfriend?" ULP-E stated ULP-C would come to the facility in between jobs and rest and eat. ULP-E stated ULP-C would volunteer to take the female residents to the store. ULP-E stated she did not report R1's concern to management because she didn't take it seriously and thought ULP-C was joking.</p> <p>During an interview with case manager (CM)-F stated R1 reported ULP-C felt uncomfortable and wanted to look for a new place to live.</p> <p>During an interview with licensed assisted living director (LALD)-A and licensed practical nurse (LPN)-B on August 1, 2023, at 10:14 a.m., LALD-A stated she was unsure why ULP-C was at the facility when he wasn't scheduled to work. LALD-A called ULP-C and ULP-C stated he was picking his food from the facility. LALD-A stated resident concerns would be reported to the nurses or LALD. The LALD-A stated, an investigation would be completed and action would be taken appropriately including reporting to the Minnesota Department of Health.</p> <p>The licensee's policy Vulnerable Adult dated March 28, 2017, indicated all caregivers who have knowledge of the abuse or neglect of a</p>	03000		

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03000	<p>Continued From page 12</p> <p>vulnerable adult or have reasonable cause to believe that a vulnerable adult is being or has been abused or neglected must report to the Administrator or Director of Nursing immediately.</p> <p>No further information provided.</p> <p>Time period for correction: Seven (7) days</p>	03000		