Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL334255184M
Compliance #: HL334258936C

Date Concluded: September 5, 2023

Name, Address, and County of Licensee Investigated:
Restful Home
1000 Reaney Avenue
St. Paul, MN 55106
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Inconclusive-Neglect
Not Substantiated-Abuse

Nature of Visit:
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 facility neglected to supervise residents which resulted in a resident sexually assaulting another resident.

In addition, the Alleged Perpetrator (AP) verbally and emotionally abused a resident when the AP threatened to kick out the resident and cause the resident to be homeless.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive and abuse was not substantiated. The resident stated the sexual assault occurred and the peer denied having any sexual contact. The facility had no evidence of sexual contact between the resident and peer, no witnesses, and neither required supervision of staff beyond twice daily room checks.

Regarding the verbal and emotional abuse, the resident did not recall the incident and the facility had no documentation or intention of implementing eviction proceedings.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, the resident's guardian, and medical provider. The investigation included review of medical records, facility incident reports, policies, and procedures related to supervision of residents, resident rights, and maltreatment of vulnerable adults. Also, the investigator observed staff/resident interactions.

The resident lived in an assisted living facility. The resident's diagnoses included visual impairment, traumatic brain injury, and alcohol abuse. The resident's service plan included assistance with medication administration, meals, laundry, housekeeping, and transportation to medical appointments. The resident's assessment indicated she had a history of depressed mood related to assignment of a guardian, and the impact on her ability to make independent decisions.

During an interview, the resident stated a peer offered to provide her with alcohol to go into her room, which was in the basement. The resident stated the peer knew when staff brought her medications and when staff would be away. The resident stated they were initially just kissing and then the peer became forceful and made her do sexual things that she did not want to do. The resident stated she did not tell anyone for months, and no longer remembered when it happened. The resident stated she wanted to move and wanted the peer to just leave her alone. During the interview, the resident denied the AP ever threatened her with eviction and stated her community team was working on a plan for a new placement.

During an interview, the peer stated he was once friends with the resident, and they had kissed once a long time ago. The peer denied ever having forced himself on the resident, and stated he now keeps his distance from the resident.

During an interview, a family member stated when the resident first talked about the incident, the facility investigated, and the resident and the peer both denied any sexual contact. The family member stated the resident's memory was not good, the resident was oversensitive, and embarrassed about her living situation.

During an interview, the AP stated he had not threatened the resident with eviction, had honored her request for a room change, and worked with her community team to bring her account up to date, which had been behind.

In conclusion neglect is inconclusive, and abuse is not substantiated.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult.

“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;
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: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility interviewed the resident and peer regarding the allegation, encouraged the peer to only approach the resident in common areas or with a staff member, and planned a discussion with the resident regarding moving to a room less isolated.

The facility contacted the resident’s guardian to address finances.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33425	A. BUILDING: _____ B. WING _____	C 08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTFUL HOME LLC	1000 REANEY AVENUE SAINT PAUL, MN 55106

(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 August 23, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL334258936C/#HL334255184M. No correction orders are issued.	0 000		