Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL337725463M
Compliance #: HL447729377C

Date Concluded: July 24, 2023

Name, Address, and County of Licensee Investigated:
The Sanctuary at Brooklyn Center
6121 Brooklyn Boulevard
Brooklyn Center, MN 55429
Hennepin County

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

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Inconclusive

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 had the resident perform home repairs for the AP.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The resident completed home repairs at the AP's private home. The resident stated the AP was a family friend and he denied feeling exploited for his labor. The AP described her relationship with the resident as that of boyfriend/girlfriend. It could not be determined if abuse occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical record, staff files, policies and procedures, and the internal investigation. Also, the investigator observed resident cares and staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes type 2 and below-the-knee amputation. The resident's service plan included assistance with medication management and the resident was independent with most activities.

The facility internal investigation document indicated a staff member witnessed the resident leaving the AP's house one morning as he boarded the Metro Mobility bus heading back to the facility. When interviewed, the AP stated the resident, and some others helped her with a household repair the day before. The AP stated the others left and the resident stayed overnight at the AP's house in a spare bedroom. The AP stated her, and the resident watched movies. The AP stated the resident had visited her house five times before. The investigation indicated the facility asked the AP directly if she was in a relationship with the resident and the AP stated she was. The AP described her relationship with the resident as that of boyfriend/girlfriend.

The facility internal investigation indicated the resident stated he did not feel he or the AP did anything wrong. The resident enjoyed helping others and knew the AP needed help with home repairs. The resident stated the AP offered to pay the resident, but he declined the payment. The resident told the facility he was not being taken advantage of and did not feel unsafe in the situation.

When interviewed, multiple staff members were aware the resident had been at the AP's ho0me. The staff stated the AP described the relationship as a boyfriend/girlfriend relationship, however, the resident did not describe their relationship in that way. The resident told staff he was helping the AP with home repairs. The resident verbalized irritation with staff questioning his actions outside the facility and did not understand why staff were concerned.

The resident declined to be interviewed, but described the AP as a family friend.

The AP declined to be interviewed.

A review of the AP's personnel file indicated the AP received training on professional boundaries.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

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.

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.

Vulnerable Adult interviewed: No, declined interview.
Family/Responsible Party interviewed: No, the resident is his own guardian.
Alleged Perpetrator interviewed: No, declined interview.

Action taken by facility:
The facility conducted an internal investigation. The AP is no longer employed by the facility.

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
	33772	A. BUILDING: _____ B. WING _____	C 07/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT BROOKLYN CENTER	6121 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55429

(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 July 5, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL337727485C/#HL337724444M and HL337729377C/HL337725463M. No correction orders are issued.	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.	