Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL339674043M
Compliance #: HL339676652C

Date Concluded: August 15, 2023

Name, Address, and County of Licensee Investigated:
Stonehaven of Eagan Senior Living
1000 Station Trail
Eagan, MN 55123
Dakota County

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

Evaluator's Name: Michele Larson
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 facility neglected the residents when they failed to provide supervision for two residents (resident #1, resident #2). Resident #2 performed oral sex on resident #1 without resident #1's consent.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although resident #2 had a history of making sexual comments and touching staff members, it was his first time to engage in a sexual act with another resident. Both resident #1 and resident #2 were alert and oriented. The incident was an unforeseeable event that the facility could not reasonably have been anticipated.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed resident #1 and resident #2's family member. The investigator contacted and interviewed law enforcement.

The investigation included review of resident #1 and resident #2's facility medical records, resident #2's facility records from previous facilities, the facility incident report, employee files, and facility policies and procedures. Also, the investigator observed resident cares and interactions during her onsite investigation.

Resident #1 and resident #2 resided in an assisted living facility. Resident #1's diagnoses included type 2 diabetes mellitus. Resident #2's diagnoses included atrial fibrillation. Resident #1 and resident #2's service plans included two daily routine safety checks. The resident #1 and resident #2's assessments indicated they were both alert and oriented to person, place, time, and situation. Resident #2 posed a risk to sexually abusing others. Staff were to alert the director of nursing (DON) regarding any sexual behaviors. Resident #2 had a history of sexually inappropriate behaviors with staff members, but no history with other residents.

The facility incident report indicated resident #1 told the executive director (ED) he had an unwanted sexual encounter with resident #2 two days prior. Resident #1 indicated after lunch resident #2 went to resident #1's apartment and performed oral sex on him. Resident #1 indicated he did not want this to occur and told resident #2 to stop but resident #2 continued. Resident #1 did not want to harm resident #2 by pushing him off, so resident #1 reported the encounter lasted between 10 to 15 minutes. The ED discussed interventions with resident #1 to prevent further incidents from occurring such as use of his call pendant to summon for help, call 911, always lock his apartment door to avoid unwanted visitors, and shout for assistance.

Resident #2's progress note indicated resident #2 moved out of the facility the same day resident #1 told the ED about the incident. Resident #2's move was scheduled by his family prior to the incident.

Review of resident #2's external records from the previous facility and current facility indicated no previous incidents of sexually inappropriate behaviors with other residents occurred.

During an interview, the ED stated the facility was aware of resident #2's past sexual inappropriateness at his prior facility but not towards residents, so the facility did not see his behaviors as a red flag. The ED stated resident #2 had poor vision and was "mostly blind." The ED stated he did not interview resident #2 since he already moved out of the facility. The ED stated resident #1 refused to be assessed at a hospital and stated resident #1 seemed a little "off" when he told his story to him, but otherwise appeared to be himself. Resident #1 indicated it was the first and only time he had a sexual encounter with resident #2.

During an interview, resident #1 stated he did not recall the incident. He stated he kept to himself and minded his own business.

During an interview, law enforcement stated the facility took appropriate action once they were aware of the incident. Law enforcement stated resident #1 appeared embarrassed about the incident. Resident #1 stated he was happy resident #2 moved out and did not want him at the

facility anymore. Law enforcement stated when interviewed, resident #2 indicated he did not recall the incident and denied it happened.

During an interview, resident #2's family member stated resident #2 was happy with the services he received at the facility but appeared uncomfortable. The family member stated she did not recall the facility contacted her about the incident. The family member stated law enforcement reported nothing significant happened. The family member stated the incident was consensual and was blown out of proportion and stated resident #2 was happy at his current facility. The family member stated resident #2 had no further incidents of sexual inappropriate behaviors since he left the facility.

In conclusion, the Minnesota Department of Health determined neglect 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.

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; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes. Resident #1 was interviewed by the investigator. Resident #2 was interviewed by law enforcement.

Family/Responsible Party interviewed: Yes. Resident #2's family member was interviewed.

Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
The facility immediately conducted an internal investigation upon finding out about the incident. The facility contacted law enforcement to investigate. The facility increased resident #2's services to include more supervision and alerted staff to report resident #2's sexual inappropriateness to the DON.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33967	A. BUILDING: _____ B. WING _____	C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEHAVEN OF EAGAN SENIOR LIVING	1000 STATION TRAIL EAGAN, MN 55123

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. INITIAL COMMENTS: #HL339676652C/#HL339674043M 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 102 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL339676652C/#HL339674043M, tag identification 620, 630, 1620, 3000.	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.	
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to comply with the requirements for reporting suspected maltreatment within 24 hours for two of two residents (R1, R2) with records reviewed. R1 had unwanted sexual contact with R2. R2 performed non-consensual oral sex on R1. 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). The findings include: R1 R1's record was reviewed. R1 admitted to the licensee's facility on March 11, 2020. R1's diagnoses included Type 2 diabetes mellitus. R1's service plan indicated R1 received assistance with personal cares and medication management. R1 used a four-wheeled walker for walking. R1's assessment dated November 1, 2022, indicated R1 was alert and oriented to person,	0 620		

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0 620	Continued From page 2 place, time, and situation. R1 was independent in operating the call system and telephone, but required occasional assistance with the call pendant and pull cord. R1 received routine safety checks at lunch and dinner time. R1's vulnerability assessment dated November 1, 2022, indicated R1 was not at risk for sexual, verbal, or physical abuse by others. R2 R2's record was reviewed. R2 admitted to the licensee's facility on October 6, 2022. R2's diagnoses included atrial fibrillation, generalized weakness, and difficulty walking. R2's admission assessment dated October 6, 2022, indicated R2 had sexual behaviors that included inappropriate comments and touching of staff members. R2 was hard of hearing and wore a hearing aid in both ears. R2 used a wheelchair for mobility but was independent with transfers and use of his wheelchair. R2's service plan dated October 12, 2022, indicated R2 received assistance with medication management, twice daily routine safety checks at 11:00 a.m. and 5:00 p.m., and sexual behavior monitoring four times per day. R2 had care alerts four times per day due to his history of verbal and physical sexual behaviors. When noticed, staff were to let R2 know his behaviors were inappropriate and they would not provide cares if it occurred. Staff were to ensure R2's safety and report his behaviors to the director of health services (DHS). R2's progress note dated October 25, 2022, at 3:40 p.m., indicated R2 made inappropriate comments and touch towards a female staff	0 620		

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0 620	Continued From page 3 member. The staff member reported R2 touched her thigh and commented, "can you get me off," and "do you know any residents that can get me off?" R2's family members were notified and advised the licensee would not tolerate R2's sexual behaviors. The licensee informed R2's family his service fees would increase as a result of his behaviors and indicated two caregivers were required when they performed services for R2. R2's vulnerability assessment dated October 31, 2022, indicated R2 posed a risk to sexually abusing others. Staff were to alert the DHS if any sexual behaviors occurred. The licensee's incident report dated November 28, 2022, at 7:11 p.m., indicated on November 25, 2022, R1 reported to executive director (ED)-F he had unwanted sexual conduct from R2 on November 23, 2022, at 1:00 p.m. Review of the Minnesota Adult Abuse Reporting Center (MAARC) reports indicated on November 25, 2022, R2 asked R1 if he could stop by his apartment after lunch. Once inside the apartment, R2 asked if he and R1 could lie down together on R1's bed. R1 agreed, but R2 climbed onto the bed through R1's legs, pulled down R1's pants, and began to suck on R1's penis. R1 indicated he told R2 to stop three times but then gave up because he did not want to hurt R2 if he pushed him off his bed. R1 indicated the incident lasted 10-15 minutes but, video footage indicated R2 spent over 50 minutes inside R1's apartment before he left. R1 indicated he did not want the incident to happen and did not consent to the sexual act. The MAARC reports were received by the state agency on November 28, 2022, at 7:15 p.m.	0 620		

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0 620	Continued From page 4 During an interview on August 2, 2023, at 1:00 p.m., ED-F confirmed he did not file the MAARC reports within 24 hours. The licensee policy titled Vulnerable Adult Reporting and Investigation, updated December 2, 2020, indicated any staff person who witnessed or suspected any form of resident maltreatment including self-neglect or resident-to-resident abuse must report the incident immediately to the DHS, and an incident report would be completed. The DHS would immediately make a web or oral based report to MAARC. Immediately, meant as soon as possible, but no longer than 24 hours from the time the incident occurred. TIME PERIOD TO CORRECT: Seven (7) days	0 620		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an Individual Abuse	0 630		

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0 630	Continued From page 5 Prevention Plan (IAPP) was updated for one of two residents (R1) with records reviewed after another resident (R2) performed oral sex on R1 without consent. 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) 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). The findings include: R1's record was reviewed. R1 was admitted to the licensee's facility on March 11, 2020. R1's diagnoses included Type 2 diabetes mellitus. R1's service plan indicated R1 received assistance with personal cares and medication management. R1 used a four-wheeled walker for ambulation. R1 was alert and oriented to person, place and time. R1's assessment dated November 1, 2022, indicated R1 was independent in operating the call system and telephone, but required occasional assistance with the call pendant and pull cord. R1 received routine safety checks at lunch and dinner time. R1's vulnerability assessment dated November 1, 2022, indicated R1 was not at risk for sexual, verbal, or physical abuse by others. The licensee's incident report dated November 28, 2022, at 7:11 p.m., indicated on November 25, 2022, R1 reported to executive director (ED)-F he had unwanted sexual conduct from R2	0 630		

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0 630	Continued From page 6 on November 23, 2022, at 1:00 p.m. A Minnesota Adult Abuse Reporting Center (MAARC) report indicated on November 25, 2022, R2 asked R1 if he could stop by his apartment after lunch. R1 indicated R2 asked if he and R1 could lie down on R1's bed. R1 agreed so R2 went through R1's legs to climb onto R1's bed, pulled down R1's pants, and began to suck on R1's penis. R1 indicated he told R2 to stop three times but then gave up because he did not want to hurt R2 if he pushed him off his bed. R1 indicated the incident lasted 10-15 minutes but, video footage indicated R2 spent over 50 minutes inside R1's apartment before he left. R1 indicated he did not want the incident to happen and did not consent to the sexual act. R1's record lacked documentation his vulnerability assessment was updated to include his new vulnerability of sexual abuse and interventions to prevent abuse. On August 9, 2023, at 1:10 p.m., the former director of nursing (DON)-G indicated she was not in the facility and was probably out on medical leave at the time the incident occurred. DON-G stated she would expect to see R1's IAPP was updated to reflect his new vulnerability. The licensee policy titled Vulnerable Adult Reporting and Investigation, updated December 2, 2020, indicated the licensee would review the resident's records including their individual abuse prevention plan during an internal investigation when maltreatment was suspected. The licensee would review, revise and implement interventions as needed to reduce the likelihood of maltreatment of the vulnerable adult.	0 630		

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0 630	Continued From page 7 TIME PERIOD TO CORRECT: Seven (7) days	0 630		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted a reassessment for one of two residents (R1) with records reviewed. R1 had unwanted sexual contact with another resident (R2).	01620		

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01620	Continued From page 8 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). The findings include: R1's record was reviewed. R1 admitted to the licensee's facility on March 11, 2020. R1's diagnoses included Type 2 diabetes mellitus. R1's service plan indicated R1 received assistance with personal cares and medication management. R1 used a four-wheeled walker for ambulation. R1 was alert and oriented to person, place and time. R1's assessment dated November 1, 2022, indicated R1 was independent in operating the call system and telephone, but required occasional assistance with the call pendant and pull cord. R1 received routine safety checks at lunch and dinner time. R1's vulnerability assessment dated November 1, 2022, indicated R1 was not at risk for sexual, verbal, or physical abuse by others. R2's record was reviewed. R2 admitted to the licensee's facility on October 6, 2022, and was discharged on November 25, 2022. R2's diagnoses included atrial fibrillation, generalized weakness, and difficulty walking. R2's service plan dated October 12, 2022, indicated R2 received assistance with medication	01620		

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01620	Continued From page 9 management, twice daily routine safety checks at 11:00 a.m. and 5:00 p.m., and sexual behavior monitoring four times per day. R2 had care alerts four times per day due to his history of verbal and physical sexual behaviors. When noticed, staff were to let R2 know his behaviors were inappropriate and they would not provide cares if it occurred. Staff were to ensure R2's safety and report his behaviors to the director of health services (DHS). R2's assessment dated November 22, 2022, indicated R2 was alert and oriented to person, place, time, and situation. R2's vulnerability assessment dated November 22, 2022, indicated R2 posed a risk to sexually abusing others. Staff were to alert the DHS if any sexual behaviors occurred. R2's progress note dated November 22, 2022, at 1:43 p.m., indicated R2 was scheduled to move out of the licensee facility on November 25, 2022. The licensee's incident report dated November 28, 2022, at 7:11 p.m., indicated on November 25, 2022, R1 reported to executive director (ED)-F he had unwanted sexual conduct from R2 on November 23, 2022, at 1:00 p.m. A Minnesota Adult Abuse Reporting Center (MAARC) reports indicated on November 25, 2022, R2 asked R1 if he could stop by his apartment after lunch. R1 indicated R2 asked if he and R1 could lie down on R1's bed. R1 agreed so R2 went through R1's legs to climb onto R1's bed, pulled down R1's pants, and began to suck on R1's penis. R1 indicated he told R2 to stop three times but then gave up because he did not want to hurt R2 if he pushed him off his bed. R1	01620		

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01620	Continued From page 10 indicated the incident lasted 10-15 minutes but, video footage indicated R2 spent over 50 minutes inside R1's apartment before he left. R1 indicated he did not want the incident to happen and did not consent to the sexual act. R1's record lacked documentation an RN reassessed R1 after his unwanted sexual contact from R2. On August 9, 2023, at 1:10 p.m., former director of nursing (DON)-G stated any RN could perform resident assessments. DON-G stated she was ill at the time the incident occurred and may have been out of the facility at that time. DON-G stated R1 should have been reassessed by an RN after his incident. The licensee policy titled, Assessment of Residents-Initial and Ongoing, updated May 23, 2022, indicated the RN would reassess the resident any time the resident had a change of services and/or a change in condition. TIME PERIOD TO CORRECT: Seven (7) days	01620		
03000 SS=D	626.557 Subd. 3 Timing of report (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 individual that occurred prior to admission,	03000		

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	33967	A. BUILDING: _____ B. WING _____	C 08/01/2023

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03000	Continued From page 11 unless: (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 (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). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (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. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (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. This MN Requirement is not met as evidenced by:	03000		

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03000	Continued From page 12 Based on interview and record review, the facility failed to comply with the requirements for reporting suspected maltreatment within 24 hours for two of two residents (R1, R2) with records reviewed. R1 had unwanted sexual contact with R2. R2 performed non-consensual oral sex on R1. 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). The findings include: R1 R1's record was reviewed. R1 admitted to the licensee's facility on March 11, 2020. R1's diagnoses included Type 2 diabetes mellitus. R1's service plan indicated R1 received assistance with personal cares and medication management. R1 used a four-wheeled walker for walking. R1's assessment dated November 1, 2022, indicated R1 was alert and oriented to person, place, time, and situation. R1 was independent in operating the call system and telephone, but required occasional assistance with the call pendant and pull cord. R1 received routine safety checks at lunch and dinner time. R1's vulnerability assessment dated November 1, 2022, indicated R1 was not at risk for sexual, verbal, or physical abuse by others.	03000		

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03000	Continued From page 13 R2 R2's record was reviewed. R2 admitted to the licensee's facility on October 6, 2022. R2's diagnoses included atrial fibrillation, generalized weakness, and difficulty walking. R2's admission assessment dated October 6, 2022, indicated R2 had sexual behaviors that included inappropriate comments and touching of staff members. R2 was hard of hearing and wore a hearing aid in both ears. R2 used a wheelchair for mobility but was independent with transfers and use of his wheelchair. R2's service plan dated October 12, 2022, indicated R2 received assistance with medication management, twice daily routine safety checks at 11:00 a.m. and 5:00 p.m., and sexual behavior monitoring four times per day. R2 had care alerts four times per day due to his history of verbal and physical sexual behaviors. When noticed, staff were to let R2 know his behaviors were inappropriate and they would not provide cares if it occurred. Staff were to ensure R2's safety and report his behaviors to the director of health services (DHS). R2's progress note dated October 25, 2022, at 3:40 p.m., indicated R2 made inappropriate comments and touch towards a female staff member. The staff member reported R2 touched her thigh and commented, "can you get me off," and "do you know any residents that can get me off?" R2's family members were notified and advised the licensee would not tolerate R2's sexual behaviors. The licensee informed R2's family his service fees would increase as a result of his behaviors and indicated two caregivers were required when they performed services for	03000		

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03000	Continued From page 14 R2. R2's vulnerability assessment dated October 31, 2022, indicated R2 posed a risk to sexually abusing others. Staff were to alert the DHS if any sexual behaviors occurred. The licensee's incident report dated November 28, 2022, at 7:11 p.m., indicated on November 25, 2022, R1 reported to executive director (ED)-F he had unwanted sexual conduct from R2 on November 23, 2022, at 1:00 p.m. Review of the Minnesota Adult Abuse Reporting Center (MAARC) reports indicated on November 25, 2022, R2 asked R1 if he could stop by his apartment after lunch. Once inside the apartment, R2 asked if he and R1 could lie down together on R1's bed. R1 agreed, but R2 climbed onto the bed through R1's legs, pulled down R1's pants, and began to suck on R1's penis. R1 indicated he told R2 to stop three times but then gave up because he did not want to hurt R2 if he pushed him off his bed. R1 indicated the incident lasted 10-15 minutes but, video footage indicated R2 spent over 50 minutes inside R1's apartment before he left. R1 indicated he did not want the incident to happen and did not consent to the sexual act. The MAARC reports were received by the state agency on November 28, 2022, at 7:15 p.m. During an interview on August 2, 2023, at 1:00 p.m., ED-F confirmed he did not file the MAARC reports within 24 hours. The licensee policy titled Vulnerable Adult Reporting and Investigation, updated December 2, 2020, indicated any staff person who witnessed or suspected any form of resident maltreatment	03000		

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03000	Continued From page 15 including self-neglect or resident-to-resident abuse must report the incident immediately to the DHS, and an incident report would be completed. The DHS would immediately make a web or oral based report to MAARC. Immediately, meant as soon as possible, but no longer than 24 hours from the time the incident occurred. TIME PERIOD TO CORRECT: Seven (7) days	03000		