*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL362524943M
**Compliance #:** HL362526516C

**Date Concluded:** October 14, 2024

**Name, Address, and County of Licensee Investigated:**
The Pillars of Prospect Park
22 Malcom Avenue Southeast
Minneapolis, MN 55414
Hennepin County

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

**Evaluator's Name:**
Katie Germann, 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) abused a resident when the AP sexually assaulted the resident during cares.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined abuse was inconclusive. The resident reported the AP raped her. The AP denied he raped the resident. The DNA swab did not detect any male DNA. The physical exam findings could not determine any definitive signs of sexual assault. It could not be determined if the AP sexually assaulted the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the law enforcement, the forensic examiner, and the SANE. The investigation included review of the facility internal investigation, police report, the forensic examination report, the SANE's report, the resident's medical record, employee training records, and staff documentation.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Parkinson's disease and dementia. The resident's service plan included assistance with bathing, toileting, transfers, medications, and meals. The resident's assessment indicated the resident had behaviors including a recent suicide attempt.

A facility investigation of the incident indicated the resident reported to unlicensed personnel the AP had raped her. The investigation detailed a timeline of events the morning of the incident. The investigation indicated the morning of the incident the AP reported he went into the resident's room and observed the resident at her bathroom sink getting ready for the day. The AP saw feces on the bathroom sink and on the resident's laptop. The AP cleaned up the feces in the bathroom and took the resident to the toilet to be cleaned up. The AP was alone in the resident's room with her for 20 minutes before he called another resident assistant to bring him more sanitary wipes. While the AP waited for more wipes, he continued to provide hygiene to the resident to remove the feces from her perineal area and buttocks. The report indicated another unlicensed personnel entered the room with additional wipes and observed the resident sitting on the toilet, she then left the room. The report indicated it was four minutes after the AP received the wipes when he and the resident exited the resident's room. When the resident came out of her room, unlicensed personnel asked the resident how she was doing, to which the resident replied, "I'm not fine, the AP raped me and wiped me up". The unlicensed personnel reported to the nurse. The report indicated the nurse interviewed the AP and asked her if the AP was inappropriate with her and if he cleaned her up. The resident responded, "He cleaned me up and then he cleaned me up". The nurse reported to the Director of Health Services, who interviewed the AP. The AP denied raping the resident. The police were called, and the resident was sent to the hospital for examination.

A police report indicated when the officer asked the resident what happened, they could make out the word "rape", but the resident would not offer more details. The report indicated the officer interviewed the AP, who told the officer on the morning of the incident he entered the resident's room to clean her and the room up from her feces. The AP told the officer the resident was getting dressed in her room, while he started cleaning up the feces in the bathroom and the laptop. He then brought her to the attached bathroom and had her stand next to the toilet where he pulled her pants down and started cleaning her and then sat her on the toilet. The AP told the officer the resident started saying, "get out" to him repeatedly. The AP told the officer he ran out of sanitary wipes and walked out of the room to ask another unlicensed personnel to assist him with getting wipes. After the unlicensed personnel gave him the wipes, he finished cleaning the resident and brought her out to the community room. The report indicated the officer also spoke with unlicensed personnel who brought the AP wipes, and the unlicensed personnel told the officer she entered the room and saw the AP cleaning the resident up and she asked if they needed anything else. The AP told her, "We got it".

A sexual assault examination indicated the resident was interviewed and had vaginal and perineal swabs collected, though the resident had discomfort so there were no inner vaginal

swabs collected. The examination indicated the resident told the nurse examiner the AP had inserted something vaginally to clean her out. The examination indicated the resident was able to name and describe the AP and stated the AP told her to spread her legs because she was fighting him, then the AP put his penis inside her and pumped. The examination indicated the resident had abrasions (minor injuries to the skin caused by rubbing or scraping the top layer of skin) on her lower back, a contusion (bruise) on her inner right arm that appeared yellow, green, and red, and diffuse erythema (area of redness) on her fossa navicularis (depression at the base of the labia). The examination indicated the vaginal and perineal swabs were sent to the Minnesota Bureau of Criminal Apprehension (BCA) for DNA testing.

Review of the BCA report indicated the vaginal and perineal swabs were tested for DNA. The report indicated based on the male versus total DNA, the swabs were not suitable for further DNA testing.

During an interview, the resident was unable to speak due to her medical conditions, but she was asked if she remembered being sexually assaulted by the AP and she nodded her head “yes”. The resident was asked if she had been hurt by the AP and she nodded her head, “yes”. The resident nodded her head “no” when asked if she felt safe in the facility. When asked if she would feel safer if the AP did not work in the facility, she nodded her head, “yes”.

During an interview, the unlicensed personnel stated morning of the incident she was in the middle of the common area passing medication when she heard the AP ask for more wipes. The unlicensed personnel asked another unlicensed personnel if she could get the wipes. She saw the AP standing in the doorway while the resident was in the bathroom. The other unlicensed personnel got the wipes. When the resident came out of her room, the unlicensed personnel asked her, “what’s up? Are you okay?” The resident said, “No I’m not, the AP raped me.” The unlicensed personnel asked her if she was sure, and she said yes. The unlicensed personnel stated the resident repeated she was raped over and over. The unlicensed personnel stated she informed the nurse of what the resident was saying.

During an interview, the facility nurse stated after he was informed of the incident, he went to talk with the resident. He sated the resident told him she was raped by the AP while she was being toileted. The nurse stated the resident told him, “He cleaned me up, then he cleaned me up.” The nurse stated he asked the resident if she would like to go to the hospital and have a rape kit done and she said yes. The nurse stated he called 911, after that he spoke with the AP and the AP told him he went into the resident’s room and found feces on her bathroom counter, the floor, and her laptop. The AP started to clean her room and take her to the toilet. The nurse stated the AP told him he took off the resident’s pants and brief and set her on the toilet. The resident told the AP to stop cleaning her bathroom and get out of her room. The AP then asked another unlicensed personnel to bring him more wipes because he ran out. The unlicensed personnel brought the wipes, and he stood the resident up and cleaned her bottom. When he finished cleaning her, he brought her out to the dining area. The nurse stated he

overheard the resident telling the emergency medical services she had pain and burning in her vaginal area. The nurse stated the AP denied any claims of abuse.

During an interview the AP stated the morning of the incident he had gotten most of the residents up for the day when he went to the resident a little later. The AP stated when he went to see her, she was sitting in her wheelchair and was starting to get ready. The AP stated he noticed there was feces on things in her room, and there was an activity they were going to do, so he wanted to clean her up. The AP stated he told the resident he was going to clean her up because there was “poop” in here and he asked to check the resident’s brief. The AP stated he then stood her up, pulled her pants down, and saw there was feces in her brief, so he sat her on the toilet and realized there were no sanitary wipes in the bathroom, so he called his coworker to bring him some wipes. The coworker brought him wipes and he got her up and put a brief on her. The AP stated he then brought her to the common area where she said he raped her. The AP stated he did not rape the resident; he did not touch the resident in any way sexually.

During interview a sexual assault nurse stated the redness to the fossa navicularis (depression at the base of the labia) could be caused by several things including trauma to the area or wiping the area to clean the resident.

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**: Yes
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: Yes

**Action taken by facility:**
The facility reported to authorities and made a report to the Minnesota Adult-Abuse Reporting Center (MAARC).

**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 |
|---|---|---|---|
| | 36252 | A. BUILDING: _____ B. WING _____ | C 09/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE PILLARS OF PROSPECT PARK | 22 MALCOLM AVENUE SE MINNEAPOLIS, MN 55414 |

| (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<br><br>On September 3, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL362526516C/#HI362524943M.<br><br>No correction orders are issued. | 0 000 | | |