Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL368704644M
Compliance #: HL368707997C

Date Concluded: May 17, 2023

Name, Address, and County of Licensee Investigated:
Angel's Health & Home Care Services
5833 Pearson Drive
Brooklyn Center, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, 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 facility staff member/alleged perpetrator (AP) sexually abused a resident when the AP engaged in a sexual relationship with the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined sexual abuse was inconclusive. Although the AP's actions were inappropriate and unprofessional, there is no evidence a sexual relationship occurred between the AP and the resident.

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 depression, generalized anxiety, and paranoid schizophrenia. The resident's service plan indicated the resident required assistance with medication management, grooming, and vital sign management. The resident's medical record indicated the resident had a history of making sexual comments towards staff and aggressive behavior.

A review of multiple text messages identified communication occurred between the resident and AP over a period of several months. The AP and the resident communicated via personal phones. The text messages included several requests by the resident for the AP to perform sexual acts on him in exchange for money. The AP declined to perform sexual acts on the resident. The text messages did not reveal evidence sexual contact occurred, however, the text messages between the AP and the resident were inappropriate and sexual in nature.

A police report identified an allegation of sexual assault involving the AP and the resident was investigated. According to the report, the resident declined to have the case pursued further against the AP. The investigating officer interviewed the resident, the AP, and facility administration regarding the sexual assault allegation and the allegation was "unfounded."

During an interview, the resident said his relationship with the AP began while he lived at the facility. The resident stated they would kiss and fondle each other through their clothing. The resident chose to move out of the facility in the middle of their relationship because the resident knew it would be "messy" if he didn't move. The resident provided a video recording he received from the AP after he moved out of the facility. The video displayed the AP lip syncing and performing gestures during a sexually suggestive song. A text message sent along with the video indicated, "since you not in the house no more here is a goodbye present." Months later, the resident tried to text the AP and she responded, "don't text my phone ignorant lying bitch", "I'll get your ass killed". Although the resident no longer resided at the facility, he reported the threatening text messages to facility administration but was not provided any follow-up made by the facility.

During an interview, the AP acknowledged she communicated with the resident via text. The AP stated the resident would make inappropriate sexual comments to her while she worked at the facility. The AP said she reported this to facility administration. As a result, the AP was temporarily removed from working at the facility without an explanation. The AP said after the resident moved out of the facility, the resident called the AP's phone repeatedly and she notified police of the repeated calls. The AP admitted she sent the resident a video, but indicated the video was sent to the resident by mistake. The AP denied any sexual contact with the resident.

During interviews with facility administration, they confirmed awareness of reported concerns and incidents between the resident and the AP. Facility administration denied knowledge of a sexual relationship between the resident and the AP.

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: NA
Alleged Perpetrator interviewed: Yes

Action taken by facility:
None.

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
	36870	A. BUILDING: _____ B. WING _____	C 03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL'S HEALTH & HOME CARE SERVICES	5833 PEARSON DRIVE 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 ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL368707997C/#HL368704644M On March 3, 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 was 1 resident receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL368707997C/#HL368704644M, tag identification 0620, 0900, 1370, 1380, 2310 and 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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (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 licensee failed to report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment and complete a thorough investigation for one of one resident (R2), with records reviewed. 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: On March 2, 2023, at approximately 10:15 a.m., a request was made to licensed assisted living director (LALD)-A and registered nurse (RN)-B to review all vulnerable adult reports the licensee had made to MAARC since December 2, 2022.	0 620		

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0 620	Continued From page 2 R2 The licensee failed to report to MAARC when R2 reported unlicensed personnel (ULP)-C was sending sexually explicit and threatening texts to R2. R2's diagnoses included, but were not limited to, depression, generalized anxiety, paranoid schizophrenia, and atrial fibrillation. R2's unsigned and undated service plan indicated R2 received medication management services, grooming assistance, and vital sign management. R2's individual abuse prevention plan dated February 5, 2022, indicated R2 was at risk to be abused. During an interview on March 16, 2023, at 11:00 a.m., R2 stated he reported to the program director and owner that unlicensed personnel (ULP-C) would do and say "nasty" things. R2 stated ULP-C should not work in healthcare. During an interview on March 17, 2023, at 10:00 a.m., licensed assisted living director (LALD-A) stated R2 reported that R2 didn't want ULP-C around him, and that ULP-C spoke to R2 inappropriately. LALD-A stated ULP-C was removed from the facility because they "weren't getting along" and when everything was calmed down and R2 and ULP-C were talking again, ULP-C returned to the facility. During an interview on March 16, 2023, at 9:00 a.m., ULP-C stated she was removed from the facility in July after she reported R2 talking to her inappropriately. ULP-C stated management never talked to ULP-C about why she was removed	0 620		

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0 620	Continued From page 3 from the facility. R2 discharged from the facility on October 14, 2022. According to video evidence, R2 received a video from ULP-C with a sexually suggestive song playing in the background with a text that included, "since you not in the house no more here is a goodbye present." According to a text message provided by R2 dated January 17, 2023, ULP-C text R2, "I'll get your ass killed." During an interview on March 16, 2023, at 11:00 a.m., R2 stated the video and text message was sent to the owner (OWN-F). R2 stated R2 talked to OWN-F about the relationship between ULP-C and R2. OWN-F stated R2, and ULP-C were consenting adults. During an interview on March 24, 2023, at 2:00 p.m., OWN-F stated he did not open a text from R2. OWN-F stated he did talk to R2 January 18, 2023. R2 told OWN-F that ULP-C was harassing and calling R2 constantly. OWN-F stated he talked to ULP-C. ULP-C said R2 was constantly calling ULP-C. OWN-F told ULP-C to block calls and text messages from R2. OWN-F stated he did not report the text because R2 was no longer a resident at the facility. Record review indicated no reports were made to Minnesota Adult Reporting Center (MAARC). The licensee's Reporting Maltreatment of Vulnerable Adult Policy undated, noted all staff providing services to a resident are mandated to report maltreatment to their supervisor or	0 620		

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0 620	Continued From page 4 MAARC. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.	0 900		

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0 900	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and execute a written contract with the required content to provide assisted living services for one of two residents (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) 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: Investigators entered facility at 9:00 a.m. on March 2, 2023. Investigators spoke with two individuals who explained one individual (R1) was a renter and the other was R1's mother, a visitor. Investigators completed document review at the licensee's main office at 10:10 a.m. on March 2, 2023. Records for R1 failed to include a written, assisted living contract with the required content. During an interview on March 2, 2023, at 10:15 a.m., licensed assisted living director (LALD)-A confirmed R1 lacked a written contract. LALD-A stated all agreements with R1 were verbal. The licensee's undated policy, Assisted Living Contracts, indicated the facility would establish a contract with each resident at the time of admission to the program and the contract would	0 900		

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0 900	Continued From page 6 include the required contract elements for compliance with the statute. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;	01370		

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01370	Continued From page 7 (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-C) completed training and competency evaluations in all required training topics. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C ULP-C was hired June 10, 2020, to perform resident direct services under the licensee's assisted living license. ULP-C's employee training records lacked evidence of successful completion of practical skills evaluations as required for training in accordance with Minnesota assisted living Statute 144G.61, Subd. 2 (a), in the following areas: -documentation requirements for all services	01370		

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01370	Continued From page 8 provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding of appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. During an interview on March 2, 2023, RN-G confirmed ULP-C's completed training documents were provided to investigators. All completed training documents were provided. The licensee policy titled, Qualifications, Training and Competency, undated, indicated all staff must be competent. Unlicensed personnel must successfully complete a training and competency evaluation prior to completing the services for a resident. TIME PERIOD TO CORRECT: Twenty-one (21)	01370		

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01370	Continued From page 9 days.	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-C) completed training and competency evaluations in all required training topics. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the	01380		

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01380	Continued From page 10 situation has occurred only occasionally). The findings include: ULP-C ULP-C was hired June 10, 2020, to perform resident direct services under the licensee's assisted living license. R2 R2 was admitted to the facility on February 12, 2022. R2's diagnoses included depression, generalized anxiety and paranoid schizophrenia. R2's assessment February 28, 2022, indicated R2 needed assistance with grooming, toileting, and bathing. R2 is alert and orientated to person, place, and time. R2's October 2022 medication administration record (MAR) indicated ULP-C administered R2's scheduled morning medications on October 13, 2022. ULP-C's employee training records lacked evidence she successfully completed practical skills evaluations as required for training in accordance with Minnesota assisted living Statute 144G.61, Subd. 2 (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation;	01380		

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	36870	A. BUILDING: _____ B. WING _____	C 03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL'S HLTH & HOME CARE SRV	5833 PEARSON DRIVE BROOKLYN CENTER, MN 55429

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01380	Continued From page 11 (6) range of motioning and positioning; and (7) administering medications or treatments as required. During an interview on March 2, 2023, RN-G confirmed ULP-C's completed training documents were provided to investigators. All completed training documents were provided. The licensee policy titled, Qualifications, Training and Competency, undated, indicated all staff must be competent. Unlicensed personnel must successfully complete a training and competency evaluation prior to completing the services for a resident. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care in accordance with accepted healthcare standards for one of three residents (R2) when R2 reported unlicensed personnel (ULP)-C spoke to R2 inappropriately and R2 didn't want ULP-C around. The licensee failed to investigate, report, and follow up on R2's concerns. The licensee removed ULP-C from the facility and allowed her to later return to the facility	02310		

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02310	Continued From page 12 and provide care to R2 without completing an investigation. 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). Findings Include: R2 admitted to the facility on February 12, 2022. R2's diagnoses included depression, generalized anxiety and paranoid schizophrenia. R2's assessment February 28, 2022, indicated R2 needed assistance with grooming, toileting, and bathing. R2 is alert and orientated to person, place, and time. ULP-C was hired June 10, 2020, to perform direct resident care services under the licensee's assisted living license. R2's employee records indicated R2 received abuse prevention and vulnerable adult training. During an interview on March 16, 2023, at 11:00 a.m. R2 stated the relationship with ULP-C started in October 2022. R2 stated ULP-C and R2 started talking with each other about their personal lives. R2 stated when ULP-C was on maternity leave she came to visit R2 at the facility, they fondled each other's private parts through their clothes. During the interview with R2 he provided personal text messages between ULP-C and R2 sent from ULP-C's personal cell	02310		

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02310	Continued From page 13 phone. Communication included requests for money and included sexual references. R2 stated after he discharged from the facility, ULP-C sent R2 a sexually suggestive video with a text message. R2 told administration he had concerns about ULP-C prior to him moving out of the facility. During an interview on March 16, 2023, at 9:00 a.m. ULP-C stated R2 and ULP- C did text back and forth. ULP-C provided personal text messages between ULP-C and R2 sent from ULP-C's personal cell phone. Not all text messages included specific dates but did display conversations between ULP-C and R2 from Tuesday, October 11th to Saturday, October 29th 2022. Communication included requests for money and included sexual references. ULP-C stated she had concerns with R2 texting her personal phone and told LALD-A. ULP-C said LALD-A removed ULP-C from the facility for a couple of weeks, but no education or disciple was provided. R2 discharged from the facility on October 14, 2022. R2 provided video evidence, of a video sent by ULP-C with a sexually derived song playing in the background with a text that included, "since you not in the house no more here is a goodbye present." According to a text message provided by R2, dated January 17, 2023, ULP-C text R2, "I'll get your ass killed." During an interview on March 17, 2023, at 10:00 a.m. LALD-A stated R2 reported ULP-C spoke to R2 inappropriately. LALD-A had a conversation	02310		

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02310	Continued From page 14 with ULP-C and decided to move her out of the facility for a while. LALD-C stated when everything was settled between ULP-C and R2, the facility had ULP-C come back to work at the facility. LALD-A stated they provided ULP-C with redirection and education of boundaries between staff and residents. LALD-A stated the facility did not complete an internal investigation. LALD-A stated education was provided to staff on boundaries and managing R2's behaviors. Record review of ULP-C's employee file did not include redirection, reeducation, or discipline regarding the incident. According to a text message provided by R2, dated January 18, 2023, R2 text OWN-F the video of ULP-C and requested a call back to discuss R2's concerns. During an interview March 16, 2023, at 11:00 a.m. R2 stated ULP-C is spiteful, vindictive, manipulative, and shouldn't work in healthcare. R2 stated after a bad argument and the text from ULP-C about having R2 killed, R2 was concerned for his safety. R2 reported the text and relationship to the facility owner (OWN-F). OWN-F did not return R2's call or text messages. R2 called his case worker and R2's case worker took him to obtain a restraining order on ULP-C. According to a text message provided by R2 dated January 18, 2023, R2 text OWN-F the video of ULP-C and requested a call back to discuss R2's concerns. During an interview March 17, 2023, at 10:00 a.m. LALD-A stated it is company protocol to complete an internal investigation and talk to all parties involved. LALD-A stated depending on the	02310		

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02310	Continued From page 15 concern, an employee could be removed or terminated. During an interview March 24, 2023, at 2:00 p.m. OWN-F stated if a resident and employee have a relationship, the facility would investigate, notify the police, and report to the state department. The licensee Employee Handbook, dated 2020, indicated sexual harassment is against the licensee's policy and is unlawful under state and federal law. Employee sexual harassment may include sexually related pictures, uninvited touching, jokes, or other sexually related comments. Sexual harassment is not tolerated and could result in disciplinary action including discharge. Reported sexual harassment will be investigated according to policy. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
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, 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	03000		

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03000	Continued From page 16 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: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment and complete	03000		

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03000	Continued From page 17 a thorough investigation for one of one resident (R2), with records reviewed. 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: On March 2, 2023, at approximately 10:15 a.m., a request was made to licensed assisted living director (LALD)-A and registered nurse (RN)-B to review all vulnerable adult reports the licensee had reported to MAARC. R2 The licensee failed to immediately report to MAARC R2's report of ULP-C talking inappropriately to R2. R2's diagnoses included, but were not limited to, depression, generalized anxiety, paranoid schizophrenia, and atrial fibrillation. R2's unsigned and undated service plan indicated R2 received medication management services, grooming assistance, and vital sign management. R2's individual abuse prevention plan dated February 5, 2022, indicated R2 was at risk to be abused. During an interview on March 16, 2023, at 11:00 a.m., R2 reported to the program director and	03000		

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03000	Continued From page 18 owner that unlicensed personnel (ULP-C) would do and say "nasty" things. R2 stated ULP-C should not work in healthcare. During an interview on March 17, 2023, at 10:00 a.m., licensed assisted living director (LALD-A) stated R2 reported that he didn't want ULP-C around him, and that ULP-C spoke to R2 inappropriately. LALD-A stated ULP-C was removed from the facility because they "weren't getting along" and when everything was calm, and R2 and ULP-C were talking again, ULP-C returned to the facility. During an interview on March 16, 2023, at 9:00 a.m., ULP-C stated she was removed from the facility around July after she reported R2 talking to her inappropriately. ULP-C stated management never told ULP-C why she was removed from the facility. R2 discharged from the facility on October 14, 2022, to a different facility. R2 provided video evidence, of a video sent to R2 by ULP-C with a sexually derived song playing in the background with a text that included, "since you not in the house no more here is a goodbye present." According to a text message provided by R2, dated January 17, 2023, ULP-C text R2, "I'll get your ass killed." During an interview on March 16, 2023, at 11:00 a.m., R2 stated the video and text message was sent to the owner (OWN-F). R2 talked to OWN-F about the relationship between ULP-C and R2. OWN-F stated R2 and ULP-C were consenting adults.	03000		

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03000	Continued From page 19 During an interview on March 24, 2023, at 2:00 p.m., OWN-F stated he did not open the text from R2. OWN-F stated he did speak to R2 on January 18, 2023. R2 told OWN-F that ULP-C was harassing and calling R2 constantly. OWN-F stated he spoke to ULP-C. ULP-C said R2 was constantly calling ULP-C. OWN-F told ULP-C to block calls and text messages from R2. OWN-F stated he did not report the text because R2 was no longer a resident at his facility. Record review indicated no reports were made to Minnesota Adult Reporting Center (MAARC). The licensee's Reporting Maltreatment of Vulnerable Adult Policy undated, noted supervisors will review the report of maltreatment and report to common entry point within 24 hours of the initial report. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		