Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL371856182M
Compliance #: HL371858961C

Date Concluded: October 30, 2024

Name, Address, and County of Licensee Investigated:
Fortunate Homes LLC
6937 France Avenue North
Brooklyn Center, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
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 alleged perpetrator (AP) sexually abused the resident when she fondled his genitals. As a result, the resident had difficulty sleeping because he did not feel safe.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. There was a preponderance of evidence the AP did not intentionally touch the resident's intimate parts. During the investigation, there were additional allegations of sexual abuse of the AP toward the resident, however the AP was not working at the facility when the alleged incidences occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a case worker. The investigation included review of the resident medical records, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator toured the facility and observed the resident's room and shower areas.

The resident resided in an assisted living facility. The resident's diagnoses included muscular dystrophy (muscle weakness), post-traumatic stress disorder (PTSD), and mood disorders. The resident's service plan included assistance with bathing, dressing, toileting, transfers, and behavior management. The resident's nursing assessment indicated he was alert and orientated. The resident had paranoia and aggressive behaviors.

A facility nurse completed a routine nursing assessment approximately three weeks prior to the incident. The assessment indicated the resident had a history of suicidal thoughts and suicidal attempts so the facility would provide frequent safety monitoring. This included safety checks when he was awake and while he was sleeping. The nursing assessment indicated the resident was verbally aggressive and resistive to cares. The nursing assessment indicated the resident played video games and altered his sleeping and gaming patterns.

During an interview, the resident said he got out of the shower and required assistance with dressing his lower body. The resident said the AP did not wear gloves and touched his genitals. The resident said the AP disguised the incident as repositioning and did not say anything to him at the time of the incident. The resident said there were many times over two-years when the AP entered his room, touched his genitals, and gave him a "hand job." The resident said sometimes he was half-asleep when these incidences occurred. The resident said this abuse occurred more often two years ago, and less frequently currently because the AP didn't work as often at the facility. The resident said two years ago the AP placed her mouth on his penis. When this occurred, the resident said he was sleeping and questioned if he was dreaming but when he woke, he realized he was not dreaming. The resident said he did not say anything to the AP at the time of the incident. The resident said he also noticed the AP taking pictures of him, not of sexual nature, on a holiday while he watched television. The resident said there were several incidences when the AP entered his room without knocking on his door.

The resident's service delivery records indicated the resident did not receive a shower on the date of the alleged incident.

The AP's employee file indicated she worked for the facility for nine months, not two years.

The facility's staffing schedule indicated the AP was not working on the holiday when the resident said she took pictures of him.

The resident's progress notes lacked documentation from the AP on the day of the incident, but there were progress notes completed by a nurse the day after the incident. These progress notes indicated a staff member (later identified as the AP) told the nurse the resident asked her to apply lotion to his entire body, including his private areas. When the AP expressed discomfort with this request the resident became verbally abusive and accused her of being incompetent. The progress notes indicated the nurse spoke to the resident and suggested he apply lotion to his private areas himself. The notes indicated the nurse told the resident if he was unable to apply lotion, she would develop a care plan for staff to assist him, but this

required further evaluation by his physician. The progress notes indicated the resident told the nurse he understood this, and he declined to have her change his care plan.

Additionally, the resident's records contained progress notes from a nurse seven days prior to the incident. These notes indicated the resident told the nurse "staff" were not knocking on his door before they entered his room. The notes indicated the nurse told the resident she spoke to staff about knocking and reminded the resident staff members need to complete safety checks on him and his use of headphones interfered with his ability to hear them knocking on his door. The notes indicated the resident told the nurse he had no further complaints and he also said he slept well. It was unclear from the documentation if "staff" meant multiple people, or solely the AP.

During an interview, a nurse said the resident was verbally aggressive, yelled at staff for basic things, and often refused assistance from them. The resident accused multiple staff members of not knocking on his door before they entered his room. He told her this was problematic because he was a young man and could be "doing what young men do." The nurse said the resident told her the AP walked in on him during one of these times and the AP did not acknowledge what he was doing. The resident told the nurse the AP was disrespectful, and he did not want her working at the facility. The nurse spoke to the AP, and she said she knocked on the resident's door, but did not receive a response from him so she entered his room. The AP asked the resident to take his medications, and he lashed out at her. The AP told the nurse she did not notice him "doing anything." The nurse said she asked the resident if there were any other concerns about the AP other than knocking on his door and the resident told her he did not have any other concerns about the AP. The nurse said the resident was generally up all night playing video games and slept during the day. The nurse said the facility required their staff members to enter his room to complete their safety checks. The nurse said the AP floated between other facilities, and there have been no concerns or complaints from staff or other residents about the care she provided. The nurse said gloves were always available for staff. The nurse said the AP no longer worked at the home where the resident lived because she was uncomfortable working with him.

During an interview, a manager said the AP worked at four other homes and she has not received any complaints from other staff or residents about the AP.

During multiple investigative interviews, staff members said the resident wore headphones which limited his ability to hear them knocking on his door.

During an interview, the AP said it was her job to check on the resident every two hours. The AP said she wore gloves when she worked with the resident and did not touching his groin or genitals. The AP said she did not take pictures of the resident. The AP said she had not put her mouth on his penis.

In conclusion, the Minnesota Department of Health determined abuse 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.

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: Not Applicable.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility provided vulnerable adult education to staff members.

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
	37185	A. BUILDING: _____ B. WING _____	C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORTUNATE HOMES LLC	6937 FRANCE AVENUE NORTH 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 October 2, 2024, the Minnesota Department of Health initiated an investigation of complaint HL371858961C/HL371856182M. No correction orders are issued.	0 000		