Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL37372001M
Compliance #: HL37372002C

Date Concluded: November 2, 2021

Name, Address, and County of Licensee Investigated:
Indigo Healthcare Services LLC
1161 Cheery Lane Northeast
Columbia Heights, MN 55421
Anoka County

Name, Address, and County of Housing with Services location:
Indigo Healthcare Services LLC
8501 Brooklyn Boulevard
Brooklyn Park, MN 55428
Hennepin County

Facility Type: Assisted Living Facility (ALF)

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

Finding: Substantiated, facility responsibility

Nature of Visit:
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.

Allegation(s):
It is alleged the resident was neglected when the facility failed to monitor and supervise the resident and she was sexually assaulted while out in the community unsupervised.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to ensure the resident was supervised based on the resident's vulnerabilities and mental capacity. The facility was aware the resident had impaired decision-making skills, was vulnerable to sexual exploitation, and did not have the mental capacity to make safe decisions. The resident left the facility, with staff knowledge, with an unknown male and was sexually assaulted.

The investigation included interviews with facility staff members, including administrative, nursing, and unlicensed staff. The resident's medical record, employee records, facility policy and procedures, and facility incident reports were reviewed. Observations of the facility and

staff and resident interaction were observed. In addition, the investigator contacted the resident's family member and law enforcement.

The resident's medical record indicated diagnoses including traumatic brain injury, oppositional defiant disorder, cognitive deficit, and attention deficit hyperactivity disorder. The facility provided services including laundry, meal preparation, reminders for grooming, bathing, and dressing, and medication administration.

The resident's county waiver assessment dated approximately 3 months prior to admission to the facility indicated the resident struggled with cognition, memory, and managing her emotions and behavior. The resident required constant monitoring and supervision and support with redirecting behaviors. Due to the resident's cognitive limitations, she was at-risk for victimization. The resident had a disregard for personal safety, was easily influenced by others, was thoughtless about boundaries, and was mentally and physically unable to make appropriate decisions and act in a potentially harmful situation. The resident was identified as at-risk for abuse or exploitation by another person, and she was not capable of ensuring her own safety or ensuring self-preservation. The assessment described the resident as "gullible" and easily manipulated by others.

Upon admission to the facility, the facility nurse completed an assessment for the resident which indicated the resident was not susceptible to abuse by others and was able to report abuse/neglect concerns. There were no further assessments, interventions, or individualized plan of care regarding the resident to ensure the residents safety.

A facility investigation indicated the resident reported to family she left the facility with a resident, Resident #2, who lived at another facility. The resident reported she went to Resident #2's home and was sexually assaulted by Resident #2. The resident reported she and Resident #2 had sexual intercourse. The family called the police to report the alleged sexual assault.

The police report indicated they were called to the facility to investigate a sexual assault. Per the report, the resident stated she thought she and Resident #2 were going to walk to the store, but they ended up walking to Resident #2's facility. The resident stated she didn't want to say no [to sex] because she was afraid Resident #2 would get mad. The resident stated she felt pressured into having sex and did not want to do it. The resident's family member stated the resident should not have been left unsupervised due to her cognitive status. The police report indicated resident #2 was a convicted sexual offender and had violated vulnerable adults in the past. Resident #2 was arrested due to the other resident's mental status, vulnerability, and inability to make safe decisions. When resident #2 was arrested, he admitted to having sexual intercourse with the other resident, and claimed it was consensual.

During an interview, the facility administrator stated the facility where the resident lives is unrelated to the facility where Resident #2 lives. The administrator stated he is employed by the two facilities and one day when working at resident #2's facility, he was driving resident #2

to work and stopped by the resident's facility to pick up some paperwork. The administrator stated he left Resident #2 in the car while he entered the resident's facility, but when he came back upstairs, Resident #2 was standing in the living room and that is likely when the resident and resident #2 met. The administrator stated the resident moved out of the facility and back home with a family member the day of the incident.

During an interview, the House Manager (HM) stated on the day of the incident the resident said she had a guest (Resident #2) coming over. When Resident #2 arrived, HM spoke to him and monitored the resident and Resident #2 while they talked in the living room. Later, the resident stated she was going to take a walk with resident #2. The HM stated he was a little concerned when he saw they were no longer on the property, and he called the resident and she stated she was fine. Later in the day, the resident and Resident #2 returned to the resident's facility. The HM stated he was going home for the day, so he took Resident #2 to work and the resident rode along. The HM brought the resident back to the facility. Later that day he was called back to the facility after the resident reported the incident with resident #2 to a family member and police arrived on site. The HM stated the resident did not tell him anything about the incident prior.

During an interview the resident's family member stated the resident called her and stated she didn't think she was a virgin anymore and that Resident #2 stuck his private part into her vagina when they were at Resident #2's facility. The family member called police and met them at the resident's facility. The family member stated the resident was at the facility for respite care, and her case manager made her level of vulnerabilities clear to the facility. The family member looked at the resident's phone and saw two calls to Resident #2 the day before the incident, and three calls the day of the incident. The family member expressed concern about how the two residents could have met in the first place.

When interviewed, the facility registered nurse (RN) stated the resident had a county waiver assessment completed. The facility procedure was to review a resident's county waiver assessment prior to admission and take that information into account when developing the Individual Abuse Prevention Plan (IAPP). The RN stated she reviewed the resident's county waiver assessment and used some of the information for the resident's IAPP. The RN did not have an explanation for why the resident's county waiver assessment indicated vulnerabilities more complex and severe in nature than the facility IAPP. The resident's vulnerability to sexual exploitation indicated on her county waiver assessment was not addressed in the facility's IAPP and no interventions were in place. The RN stated there was no specific direction to staff regarding the resident's care because the resident plan of care was still being developed when she left the facility.

In conclusion, neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

"**Substantiated"** means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

"Neglect" means:

(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: The resident's family member requested the investigator not interview the resident.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility completed an incident report. The resident moved out of the facility.

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,

Or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding.

cc:
The Office of the Ombudsman for Long-Term Care
Hennepin County Attorney
Brooklyn Park City Attorney

Brooklyn Park Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37372	A. BUILDING: _____ B. WING _____	C 10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIGO HEALTHCARE SERVICES LLC	**8501 BROOKLYN BLVD. BROOKLYN CENTER, MN 55428**

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, the Minnesota Department of Health issued a correction order(s) pursuant to an 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: On October 20, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL37372002C/#HL37372001M. At the time of the evaluation, there were #5 residents receiving services under the assisted living license. The following correction orders are issued for #HL37372002C/#H37372001M, tag identification 0250, 0630, and 2360.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
0 250 SS=F	144G.20 Subdivision 1. Conditions	0 250		

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0 250	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04;	0 250		

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0 250	Continued From page 2 (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the residents' assisted living services, understood all of the assisted living provider regulations; and the licensee failed to ensure policies and procedures were developed and/or implemented. This had the potential to affect all five residents residing in the facility. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On October 20, 2021, at approximately 10:30 a.m., the licensee's assisted living policies and procedures were provided by the housing	0 250		

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0 250	Continued From page 3 manager (HM)-C. The policies and procedures provided by HM-C were based on comprehensive home care statutes, despite the facility being licensed for assisted living. The following policies were requested and reviewed: -Policy Acceptance of Clients dated March 1, 2015; Reference: MN Statute 144A.479.11, subd. 4 -Policy Adverse Events dated March 1, 2015; No reference provided -Policy Clinical Records dated March 1, 2015; Reference: MN Statute 144A.4794 -Policy Delegation of Home Care Tasks dated March 1, 2015; Reference: MN Statute 144A.4793 and 144A.4795, Subd. 4 & 7. -Policy Discharge of Clients dated March 1, 2015; Reference: MN Statute 144A.4791, Subd. 10 -Personnel Records dated May 7, 2017; Reference: MN Statute 144A.479, Subd. 7 -Policy Staff Competency dated March 1, 2015; Reference: MN Statute 144A.4795 -Policy Staff Orientation and Education dated March 1, 2015; Reference: MN Statute 144A.4795 and 4796 -Policy Supervision-Comprehensive Services dated March 1, 2015; Reference: MN Statute 144A.4797 -Policy Vulnerable Adult/Child Protection dated March 1, 2015; Reference: MN Statutes 626.556 and 626.557 On October 20, 2021, at approximately 1:50 p.m., HM-C stated the above noted policies and procedures were not developed or updated in accordance with current assisted living statutes and were not aligned with the facility's current assisted living license. No further information was provided.	0 250		

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0 250	Continued From page 4 TIME PERIOD FOR CORRECTION: Seven (7) days	0 250		
0 630 SS=G	144G.42 Subd. 6 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 prevention plan was developed for two of two residents (R1, R2) reviewed for content of abuse prevention plans. R1 was identified as requiring supervision due to increased risk of victimization: however, no assessment or interventions were completed to minimize the risk of abuse. R1 left the facility with an unknown male and was sexually assaulted. This practice resulted in a level three violation (a violation that harmed a client'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	0 630		

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0 630	Continued From page 5 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: R1's MnChoices county waiver assessment dated June 21, 2021, (3 months prior to R1's admission to the facility) indicated R1's vulnerabilities included R1 was susceptible to victimization due to cognitive limitations. The assessment indicated R1 engaged in behaviors that would or potentially could increase her level of risk, harm, or exploitation by others, such as befriending strangers. The assessment indicated it was critical for R1 to receive ongoing support and supervision due to increased risk of victimization. R1's facility Vulnerability Assessment dated September 22, 2021, indicated R1 was not susceptible to abuse by others. The assessment also indicated R1 possessed functional limitations, but no interventions for managing the limitations were documented. A facility incident report dated September 28, 2021, indicated R1 returned home and stated she had been sexually assaulted by a male who had been at the facility earlier that day. The facility notified law enforcement. The police report dated September 28, 2021, indicated R1 met a male the prior day when he was brought to the facility by a staff member. On September 28, 2021, the male and R1 left the facility and walked to the male's residence. R1 stated she was afraid the male would get mad at her if she declined sexual intercourse. The police report indicated the male was a convicted sex offender and had sexually abused vulnerable	0 630		

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0 630	Continued From page 6 adults in the past. R1 did not have the cognitive capacity to consent to sexual intercourse. R1 suffered a traumatic brain injury in a car accident and maintained low-functioning cognitive status as an outcome. Due to R1's vulnerabilities and the male's history as a sex offender, the male was arrested and taken into custody. During interview on October 22, 2021, at 11:19 a.m., the facility registered nurse (RN)-1 stated she did review R1's MnChoices assessment prior to completing the resident's Vulnerability Assessment. RN-1 verified R1's Vulnerability Assessment did not identify R1's vulnerabilities or identify interventions to be implemented to keep the resident safe. R2's MnChoices county waiver assessment dated July 27, 2020, indicated R2's vulnerabilities included R2 was susceptible to victimization, including financial exploitation, physical exploitation, and sexual exploitation. The assessment indicated R2 engaged in behaviors that would or potentially could increase her level of risk, harm, or exploitation by others, such as befriending strangers. R2's facility Vulnerability Assessment dated August 4, 2021, indicated R2 was not susceptible to abuse by others. The assessment also indicated R2 possessed functional limitations, but no interventions for managing the limitations were documented. During an interview on October 22, 2021, at 11:19 a.m., RN-1 stated R2's Vulnerability Assessment did not contain R2's specific vulnerabilities. RN-1 stated the facility procedure was to review each resident's MnChoices assessment or any other assessment provided and take that into account	0 630		

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0 630	Continued From page 7 when creating resident vulnerability assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure 1 of 5 residents reviewed, Resident 1, was free from maltreatment. The resident was neglected. Findings include: On October 20, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	