Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305191525M **Date Concluded:** October 28, 2022

Name, Address, and County of Licensee Investigated:
Traditions of Owatonna
195 24th Place NW
Owatonna, MN 55060
Steele County

Facility Type: Assisted Living Facility (ALF) **Evaluator's Name:** James P. Larson
Special Investigator

Finding: Inconclusive

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.

Initial Investigation Allegation(s):
The unlicensed personnel (ULP)/alleged perpetrator (AP) sexually abused the resident when she grabbed the resident's groin area.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined sexual abuse was inconclusive. Conflicting accounts of the incident were provided. The AP denied abusing the resident and there was no witness to the alleged incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also interviewed the resident's family. The investigator conducted an onsite visit, which included review of facility policies and procedures as well as resident and personnel records. Police reports were also reviewed.

The resident resided in an assisted living facility. The resident's diagnoses included major depressive disorder, mild anxiety disorder, chronic obstructive pulmonary disease. The resident's service plan included assistance with medication management and activities of daily living. Facility assessments identified the resident had a history of inaccurate reporting of theft and relationship status, towards staff and family members. Due to the history of false allegations, two staff were required to be present for all cares provided to the resident. Facility staff was directed to monitor the resident's behavior and immediately report any accusations to the nurse.

Documentation indicated facility administration learned of the allegation of sexual abuse from the unlicensed personnel (ULP)/alleged perpetrator (AP). The AP was informed by an individual at the facility of the allegation that the AP "sexually pleasured her [the resident] with her [AP] fingers".

Immediately upon learning of the allegation, the AP had the individual accompany her to the conference room to inform administration of the accusation. The individual reported to administration the resident had said the AP "put her fingers in her [resident]".

Administrative staff immediately filed a vulnerable adult report and began an internal investigation into the alleged incident. The AP was immediately suspended and did not return to the facility.

During an interview, the AP indicated she immediately self-reported the accusation to administration as directed by the resident's plan of care. The AP stated she had interacted with the resident the evening prior but did not provide any personal care. The AP indicated the only contact she had with the resident the previous day was during medication administration. The AP denied abusing the resident.

During an interview with the resident, she indicated she was seated in her wheelchair fully clothed when the AP was administering medication. The resident went on to explain the AP grabbed her, "down there", over her clothing with one hand on the front of her groin area after she administered her medication. The resident stated nothing like this had previously happened with the AP, the AP had been removed from the facility and she now felt safe residing in the facility.

During an interview with administration, they stated no corroborating statements were made by staff or other facility residents during the internal investigation. There was no witness to the alleged incident. Administration indicated the AP was a contracted staff member, and not an employee of the facility. The staffing agency and local police were informed of the allegation.

During an interview with the resident's family member, they indicated that they have no current concerns with the care provided at the facility.

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 completed an internal investigation. The AP was removed from the facility schedule and no longer assigned to this or any of the company's associated facilities.

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
	30519	A. BUILDING: _____ B. WING _____	C 10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF OWATONNA	195 24TH PLACE NW OWATONNA, MN 55060

(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 On October 13, 2022, the Minnesota Department of Health initiated an investigation of complaint HL305192966C/#HL305191525M. No correction orders are issued.	0 000		