DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL33772001M

Date Concluded: August 12, 2022

Name, Address, and County of Licensee Investigated:
The Sanctuary at Brooklyn Center
6121 Brooklyn Blvd
Brooklyn Center, MN 55429
Hennepin County

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

Evaluator's Name: Yolanda Dawson, RN
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 alleged perpetrator (AP) sexually abused the resident when he touched the resident's breasts and peri area inappropriately and videotaped her while assisting with a shower.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined sexual abuse was inconclusive. While the resident was consistent with the account of the incident, there was not a preponderance of evidence the AP acted inappropriately. The AP provided conflicting interviews with his account of the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the resident's family. The investigation included review of resident records, policies and procedures and the police report.

The resident resided in an assisted living facility. The resident's diagnoses included right sided weakness, hip pain, schizoaffective disorder, and major depressive disorder. The resident's service plan included assistance with showering. The resident's assessment indicated the resident was independent with ambulation and wheelchair transfers.

The facility received a report of an allegation of sexual abuse involving the resident and the AP. It was alleged the AP touched the resident's breasts and peri area inappropriately and videotaped the resident while assisting with a shower. Upon learning of this allegation, the facility reported the incident, began an internal investigation, and immediately suspended the AP.

The facility internal investigation document indicated the resident requested assistance with a shower and peri area care, and the AP assisted the resident without issue. The AP reported he also assisted the resident to dry off after the shower. The AP reported he was not on his phone when assisting the resident and did not record the incident. The AP's personal and work phones were reviewed for video footage, and none was present.

During an interview with the investigator, the AP stated the resident pushed her call pendent for assistance and he answered it. The AP stated he did not provide assistance to the resident to wash her body and that she washed herself. The AP stated the resident was independent with showering and only needed standby assistance due to a risk for falls. The AP denied he assisted the resident out of the shower. The AP denied that he had his phone while in the resident's room, and that he left his personal phone and work phone on the cart in the hallway.

During an interview, the resident stated while she was in the shower the AP had his phone up to his face and made the remark "oh yeah". The resident stated she asked the AP to assist with washing her back and backside, but he did more and went all the way to the front. The resident stated she requested his hand for assistance getting out of the shower and he pushed his hand into her breast. When she asked him to take it away, he pushed harder, before removing his hand. The resident stated that prior to the incident she did not have a problem with the AP, and he was a nice man.

During an interview, a family member stated the resident reported to him that someone had touched her inappropriately. The family member indicated the resident had a history of hallucinations and he did not know what to believe. The family member stated the resident did not appear to be in distress or have a change in behavior at the time of the incident. The family member did not have concerns with the care provided at the facility.

The police report indicated the case was closed and no charges were filed in relation to this incident.

In conclusion, the Minnesota Department of Health determined sexual 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.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
An internal investigation was conducted. The AP was removed from the resident's care team. A MAARC report was completed, and police were notified.

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
	33772	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT BROOKLYN CENT	6121 BROOKLYN BOULEVARD 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 Initial comments On July 7, 2022, the Minnesota Department of Health initiated an investigation of complaint HL33772001M/HL33772002C. No correction orders are issued.	0 000		