Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL359883407M
Compliance #: HL359885609C

Date Concluded: December 3, 2022

Name, Address, and County of Licensee Investigated:
Noah Home Care Inc
13521 Nicollet Lane
Burnsville, MN 55337
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Stacia Hansen, 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 facility neglected resident #1 and resident #2 when resident #2 raped resident #1.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Resident #1 stated the rape occurred, but the investigation did not find corroborating evidence. Additionally, resident #1 made statements indicating the event may have not occurred.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigation included review of resident records, police report, hospital records, and policies and procedures. Also, the investigator toured the facility and observed resident/staff interactions.

The residents resided in the same assisted living facility.

Resident #1's diagnoses included paranoid schizophrenia, anxiety, and insomnia. Resident #1's service plan included assistance with medication administration and management. Resident #1's assessment indicated due to mental health and behavior is a potential risk for abuse.

Resident #2's diagnoses included schizo-affective disorder, anxiety, and depression. Resident #2's service plan included assistance with medication administration and management. Resident #2's assessment indicated resident #2 had a history of sexual abuse and required close monitoring around other residents.

The facility's incident report indicated one evening after dinner resident #1 approached resident #2 and stated, "you raped me". The incident report indicated resident #1 reported to police the sexual assault happened 2 months prior but then retracted his statement and denied it occurred.

Law enforcement (LE) records indicated resident #1 reported he was raped by resident #2. The report indicated resident #1 said resident #2's performed anal sex on resident #1 for approximately one minute. The same document indicated this occurred in resident #1's room after which resident #2 left the room. The LE report indicated resident #2 denied any sexual contact ever occurred between him and resident #1. The LE report indicated resident #1 told a LE officer he "thinks" he was raped but could not confirm anything occurred as it may have been a dream.

Resident #1's hospital records indicated resident #1 stated he had been raped two months prior to hospitalization. The same records indicated he said he was "cut open" and assaulted. The hospital records indicated a sexual assault exam would not be beneficial and there were no signs of trauma to his genitals where he stated he had been cut open. The hospital records indicated resident #1 made delusional statements while hospitalized and a family member said he seemed to have increased paranoia. Resident #1 admitted to the hospital for evaluation, stabilization, and treatment for a diagnosis of paranoid schizophrenia and agitation.

During an interview, the administrative staff member stated she received a phone call from an evening facility staff member who reported resident #1 made the allegation against resident #2. The administrative staff member stated she advised the facility staff member to immediately contact the police for an investigation. The administrative staff member stated they also notified the residents' family members and case managers of the incident.

In conclusion, the Minnesota Department of Health determined neglect 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means 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.

Vulnerable Adult interviewed: The attempts to interview resident #1 and resident #2 were not successful
Family/Responsible Party interviewed: Resident #1's guardian/family member did not return phone calls
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility contacted law enforcement.

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
Burnsville Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35988	A. BUILDING: _____ B. WING _____	C 11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOAH HOME CARE INC	13521 NICOLLET LANE BURNSVILLE, MN 55337

(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, 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: #H359883775C/#HL359882122M, #HL359882021M/#HL359883690C, and HL359883407M/HL359885609C On November 9, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued as immediate correction orders. At the time of the complaint investigation, there were 2 residents receiving services under the provider's Assisted Living license. The following immediate correction order is issued. The following correction order is issued for #H359883775C/#HL359882122M, #HL359882021M/#HL359883690C, and HL359883407M/HL359885609C tag identification 0470.	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	

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0 470	Continued From page 1	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the licensee failed to ensure one or more persons were available to respond to the requests of residents for assistance with health or safety needs 24-hours per day, seven days per week when the only staff member in the facility left to run an errand, leaving two residents (R1	0 470		

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0 470	Continued From page 2 and R2) alone in the facility. This had the potential to affect the two residents receiving services from the licensee. 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 of the residents). The findings include: R1's medical record indicated the resident moved into the facility on September 16, 2021, due to a diagnosis that included paranoid schizophrenia. R2's medical record indicated the resident moved into the facility on June 2, 2022, due to diagnoses that included bipolar disorder and mixed personality disorder. On November 9, 2022, at 10:15 a.m. a Minnesota Department of Health (MDH) investigator knocked on the facility door, but no one answered. The MDH investigator knocked again but still no one answered the front door to the facility. On November 9, 2022, at 10:19 a.m., the MDH investigator contacted the provider at Noah Home Care by phone. Administration Manager (AM)-A answered the phone and stated she was running an errand and would be back at the facility in a few minutes. On November 9, 2022, at 10:35 a.m., the MDH investigator observed AM-A arrived at Noah	0 470		

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0 470	Continued From page 3 Home Care. During this same observation, the MDH investigator entered the building and observed no staff member present aside from AM-A. On November 9, 2022, at 11:00 a.m., the MDH investigator requested a copy of the licensee's posted Employee Schedule, but AM-A reported it was not correct and printed a current one, which indicated the following: Morning staff: AM-A 9:30 a.m.-3:30 p.m. Evening staff: unlicensed personnel (ULP)-B 3:30 pm-10:00 p.m. Night staff: ULP-C Sunday to Wednesday 10:00 pm- 9:00 a..m. Night Staff: ULP-D Thursday to Saturday 10:00 pm- 9:00 a.m. During a phone interview on November 9, 2022, at 1:00 p.m., AM-A stated they normally do not leave residents home alone and she was gone for a short time to purchase an item for the facility. AM-A stated there are cameras throughout the facility and the residents were sleeping. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 470		