Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL31673002M, HL316752845M
Compliance #: HL306504889C, HL316754652C

Date Concluded: January 11, 2023

Name, Address, and County of Licensee Investigated:
White Pine Senior Living Blaine 2
12402 Jamestown Street NE
Blaine, MN 55449
Anoka County

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

Evaluator's Name: Lissa Lin, RN
Special Investigator

Finding: Not Substantiated

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 residents (resident 1, resident 2 and resident 3) when staff failed to supervise the three residents when resident 2 sexually abused resident 1 and resident 3 in memory care when he initiated oral sex with them.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Facility staff found resident 2 performing oral sex on resident 1 and resident 3 on two separate occasions. Staff immediately separated the men. Resident 1 and resident 3 told the nurse they had no problem with the sexual contact but later gave conflicting answers that the sexual contact with resident 2 was unwanted or did not happen. Staff used interventions from the abuse prevention plans to keep all three residents safe, documented and reported the incidents to the nurse and notified the family members.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members and a guardian. The investigator interviewed resident 1. The investigation included review of resident records, incident reports, staff schedules, policies and procedures and concerns. The investigator observed resident 1, resident 2 and resident 3 in the men's memory care unit participating in activities and socializing with staff and each other.

Resident 1 lived in the men's assisted living memory care unit. The resident's diagnoses included dementia and cerebral palsy. The resident's service plan included assistance with medication administration, wellness checks and behavioral interventions. Resident 1's assessment indicated he was not verbally or physically threatening but had inappropriate sexual behaviors towards others including sexual abuse with female residents at another location and a sexual encounter with a male. Staff were to remove resident 1 from any abusive or inappropriate situations and redirect using interventions listed on his abuse prevention plan.

Resident 2 lived in the men's assisted living memory care unit. Resident 2's diagnoses included dementia. Resident 2 used a wheelchair for mobility. His service plan included assistance with behavioral interventions, wellness checks, help with dressing and grooming. Resident 2's assessment indicated he was non-verbal and unable to communicate his needs, but could be verbally abusive and threatening to others, had a history of public masturbation and touching other male and female residents. Staff were to remove and redirect resident 2 from abusive or inappropriate situations using interventions listed on his abuse prevention plan.

Resident 3 lived in the men's assisted living memory care unit. Resident 3's diagnoses included hypertension and lung disease. The resident's service plan included assistance with behavioral interventions, meal assistance, cueing for dressing and grooming. Resident 3's assessment indicated he could be verbally abusive to others and displayed inappropriate sexual behaviors towards others. Staff were to remove and redirect resident 3 from abusive or inappropriate situations using interventions listed on his abuse prevention plan.

One morning, a staff member went to resident 3's room to get him up and ready for breakfast. The staff person saw resident 3 in his bed with his pants pulled down and his genitals exposed. Resident 2 was performing oral sex on resident 3. The staff person removed resident 2 from the room. The nurse was notified; both residents were assessed for injuries. An incident report was completed, and the nurse contacted resident 2's family member and resident 3's guardian about the incident. A "stop" sign was placed on the exterior of resident 3's door to discourage anyone from entering his room and the door is kept closed.

Approximately two weeks later, a staff member entered resident 1's room and saw him lying on his bed while resident 2 performed oral sex on him. The staff member told resident 1 to pull his pants up and moved resident 2 back to his room and changed him into a one-piece jumpsuit (one of the abuse interventions listed for resident 2) and completed an incident report. The nurse assessed the residents for injuries, and family members were contacted.

During an interview, resident 1 was unsure how long he had lived in the building, thought it was “about two weeks” and said he felt safe living in the men’s unit, no one enters his room or bothers him.

During an interview, a nurse said resident 2 has frontal lobe dementia so his behaviors will not go away. Resident 1 told her he did not stop resident 2 from performing oral sex on him and he enjoyed it. Resident 3 also told the nurse he enjoyed the oral sex and did not ask resident 2 to stop. Resident 3 also said his father would be upset because what happened should be between a man and a woman. The nurse said a mental health counselor was brought in to meet with resident 3.

A former staff nurse said there were some very aggressive residents in the men’s memory care unit. The goal was to keep everyone safe and try different things, interventions to keep incidents from happening again.

Resident 1’s family member said resident 1’s transfer to the men’s unit was supposed to decrease or stop the sexual behaviors but it has not. She said she asked him about any unwanted touching from other residents and resident 1 said he would not let that happen. The family member said she is frustrated and wants resident 1 moved back to the previous place where he was happier, received better care and was an hour closer to her so she could visit more often.

Resident 2’s family member said she is kept informed of any incidents. Staff have tried more interventions with resident 2, including adjusting the times some of his medications are given and involving him in more activities. She said resident 2 has had fewer behavior incidents recently.

Resident 3’s guardian said he struggles with memory but can make his needs known. She said she is informed of any incidents and has no concerns about his safety or cares.

An unlicensed staff member who witnessed the sexual contacts did not respond to multiple interview requests.

In conclusion, it was inconclusive whether abuse occurred.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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.
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: Interview with resident 1, no Tennessen due to attention/cognition. Unable to interview resident 2 or resident 3.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility staff separated the residents, assessed for injuries, notified the registered nurse and completed incident reports. The facility reported the incidents to the Minnesota Adult Abuse Reporting Center. The nurse implemented additional interventions such as more activities to keep residents busy and out of their rooms.

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
	31675	A. BUILDING: _____ B. WING _____	C 11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAINE WHITE PINE II	12402 JAMESTOWN STREET NE BLAINE, MN 55449

(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 November 30, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL316751022C/#HL316753002M and HL316754652C/HL316752845M. No correction orders are issued.	0 000		