*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL333115242M
**Compliance #:** HL333117164C

**Date Concluded:** November 7, 2024

**Name, Address, and County of Licensee Investigated:**

Lewiston Senior Living
505 E Main St
Lewiston, MN 55952
Winona County

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

**Evaluator's Name:** Lena Gangestad, RN
Special Investigator

**Finding:** Inconclusive

**Nature of Investigation:**
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 abused the resident while applying lotion to her shoulder, then proceeded to apply lotion to her breasts and rubbed them. A few days later, while again applying cream to her back, the alleged perpetrator rubbed the resident's buttocks with both hands, making her feel uncomfortable.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined abuse was inconclusive. Due to incomplete and conflicting accounts of the incidents, it could not be determined if maltreatment occurred. The resident declined to be interviewed while the alleged perpetrator denied the allegations and there were no witnesses.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records,

internal investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include borderline personality disorder and chronic pain syndrome. The service plan included assistance with medications. The same document indicated the resident had chronic or recurring itchiness, rashes, and dry skin. The resident's assessment indicated she was independent with transfers and mobility.

One evening, the resident reported to one of the unlicensed caregivers that two weeks earlier the alleged perpetrator, who was also an unlicensed caregiver, applied lotion to her shoulder but also applied the lotion to her breasts and rubbed them. The resident also said that a few days after the initial event, the alleged perpetrator was applying lotion to her back and rubbed the resident's buttocks with both hands, making her feel uncomfortable.

During the interview, a manager stated the unlicensed caregiver reported to her what the resident had said so she immediately spoke with the resident and began the investigation. The manager stated resident did not provide much information about the incident. The manager also spoke with the alleged perpetrator, who said she only applied lotion to the resident's collarbone and never below the waist. The manager instructed the alleged perpetrator was assigned to a different area to work outside of the memory care and if the alleged perpetrator entered the resident's room accompanied by another team member.

During the interview, the alleged perpetrator stated she no longer provided cares for the resident after the resident made her claims. If the memory care unit needed help and she needed to go into the resident's room, she only did so when accompanied by another staff member. She also said that when she applied ointment/lotion to the resident, she applied it only to her shoulder and lower back only. She stated she did not apply it anywhere else or attempt to touch the resident inappropriately.

During the interview, a police officer stated the resident had reported such incidents in the past but generally declined to discuss them when law enforcement inquired.

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; or
(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 unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(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**: No, the resident refused.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: Yes.

**Action taken by facility:**
The facility did an internal investigation, filled the report to Minnesota Adult Abuse Reporting Center and notify the police department.

**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 |
|---|---|---|---|
| | 33311 | A. BUILDING: _____ B. WING _____ | C 09/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LEWISTON SENIOR LIVING | 505 EAST MAIN STREET LEWISTON, MN 55952 |

| (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<br><br>On September 26, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL333115281M/HL333117222C, and #HL333115242M/HL333117164C. No correction orders are issued. | 0 000 | | |