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 #: HL350216802M
Compliance #: HL350211325C

Date Concluded: November 27, 2024

Name, Address, and County of Licensee Investigated:
Watchful Caregivers
3806 57th Avenue North
Brooklyn Center, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck
Special Investigator

Finding: Not Substantiated

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 (AP) abused a resident when the AP sexually touched the resident whenever bathing the resident, causing fear and emotional pain.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although there was a report of sexual abuse, the resident denied the allegation, there was no identified AP, and there was no additional evidence of suspected sexual abuse found by the facility or the Minnesota Department of Health investigation.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted a family member and law enforcement. The investigation included review of the resident records, hospital records, ambulance records, facility internal investigation, personnel files, staff schedules, law enforcement reports, related facility policy and procedures. Also, the investigator observed staff/resident interactions.

The resident lived in an assisted living facility due to diagnoses that included quadriplegia and ventilator dependence. The resident's service plan included full assistance with bathing, dressing, eating, hygiene, turning/repositioning, medications, and incontinence cares. The resident's assessment indicated the resident experienced anxiety and received interventions of as needed medications as well as one to one time with a nurse, when feeling anxious.

The resident's progress note indicated a non-emergency transportation vehicle arrived to bring the resident to the hospital for a scheduled appointment to replace her suprapubic catheter, due to leaking. The progress note indicated the resident met with paramedics in the ambulance and they denied the assigned male nurse entry as they wanted to interview the resident. The progress note indicated the paramedics requested a female nurse accompany the resident in the ambulance.

During an interview, the female nurse stated paramedics asked her to accompany the resident to the hospital in the ambulance but did not state why. The nurse stated she and the resident waited for several hours before anyone came to talk with them. The nurse stated a hospital staff came into the room and asked the nurse to leave so they could interview the resident about a report of sexual activity at the facility. The nurse stated two more hours passed and a hospital staff told the nurse that they were admitting the resident to the hospital but did not say why. The female nurse stated she did not file a report with the state as she had no information and assumed the hospital would file a report if they suspected abuse.

Hospital records indicated the resident refused to participate in a sexual assault exam.

During several interviews, male and female facility nurses stated the resident had anxiety and preferred female caregivers. The nurses stated the resident was alert, oriented, and spoke up for herself, and sometimes refused cares. The nurses stated the resident required assistance of two to three staff for bathing, turning, and repositioning. The nurses stated they had three nurses working each shift to care for three ventilator-dependent people living in the facility. The nurses stated they would alter care times to accommodate resident's needs, as they always required a female in the room for the resident.

During an interview, a family member stated the resident had expressed concerns about men since she became paralyzed and always preferred the company of women. The family member stated the resident had experienced changes to her personality. The family member stated reports of sexual assault were consistent with the resident's pattern displayed in order to admit to the hospital. The family member stated she had positive interactions with staff at the facility and felt they did a really good job with the resident's cares and keeping her safe.

During an interview, the resident stated no one had sexually abused her. The resident stated she felt more comfortable when female staff assisted her with bathing, peri-care, and other

cares related to her private areas. The resident stated she felt safe at the facility as there was always a female staff.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility changed the resident's services to include a female staff at all times and increased the number of staff required for bathing the resident.

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
	35021	A. BUILDING: _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATCHFUL CAREGIVERS LLC	**3806 57TH AVENUE NORTH 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 On November 21, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL350211325C/#HL350216802M. No correction orders are issued.	0 000		