Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304066242M
Compliance #: HL304069282C

Date Concluded: November 15, 2024

Name, Address, and County of Licensee Investigated:
Sunrise Village of Milaca
115 Ninth Street NW
Milaca, MN 56353
Mille Lacs County

Facility Type: Assisted Living Facility (ALF)

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 (AP), who was an unlicensed caregiver, abused the resident when he tried to kiss and have sex with the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Due to conflicting accounts of the incident, it could not be determined if maltreatment occurred. The AP denied the allegations, and there was no witness to the incidents.

The investigator conducted interviews with administrative staff and the resident. The investigation included review of the resident's records, AP's personnel files and internal investigation documentation, staff schedules, policies, and procedures.

The resident resided in an assisted living facility. The resident's diagnoses depression disorder and anxiety. The resident's service plan included assist of two person with sit to stand equipment for mobility.

One day, the resident reported to the unlicensed caregiver that the AP attempted to kiss her and forced his tongue into her throat.

During an interview, the resident stated that the AP came to her room every time he worked and continuously attempted to engage in sexual activities with her from the time he began working until he was no longer employed. She said that she repeatedly asked him to stop, but he persisted. Eventually, she felt overwhelmed and decided to report the incidents to the manager.

During an interview, the AP denied ever attempting to kiss or touch the resident inappropriately. The AP stated that during his interview with a manager at the facility he said the resident was often upset when discussing her inability to live independently and her limited freedom to go out as she wished. The AP stated on some occasions, the resident would ask for a hug, and he would offer a side hug, placing his right arm over her shoulders, to comfort her. He stated he never crossed any boundaries with the resident.

During an interview, the manager stated she became aware of the incident when an unlicensed caregiver [other than the AP] reported it to her. She subsequently reported the situation to the police and conducted separate interviews with the resident and the AP. The manager stated the AP was suspended immediately upon her learning of the incident. The AP denied the allegation and later resigned after securing a different job. Additionally, the manager state neither other residents nor staff had expressed any concerns regarding the AP's behavior.

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: Yes.
Family/Responsible Party interviewed: No. The family was not involved in the resident's care.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility suspended the AP. They started investigation and notified the police.

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
	30406	A. BUILDING: _____ B. WING _____	C 11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE VILLAGE OF MILACA	115 9TH STREET NW #120 MILACA, MN 56353

(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 4, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL304066242M/HL304069282C. No correction orders are issued.	0 000		