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Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Texas Terrace Care Center
7900 West 28th Street
St. Louis Park, MN 55426
Hennepin County

Report #: H5187039

Date: 8/31/2009

Date of Visit: 7/10/2009
Time of Visit: 8:20 a.m.

By: Lori Wear, R.N.
Special Investigator

Christine Bodick-Nord, R.N.
Special Investigator

Nature of Visit:
An unannounced visit was made in order to investigate the following allegation of sexual abuse in accordance with federal regulations for long term care facilities at 42 CFR Part 483, Subpart B. In conjunction with the federal investigation, an investigation was also conducted in accordance with the Vulnerable Adults Act (VAA), Minnesota Statutes §626.557 and state nursing home licensing rules, Chapter 4658.

The allegation is: Sexual abuse occurred when, on 7/6/2009, employee (F)/nursing assistant (NA)/the alleged perpetrator (AP) kissed resident #1 on the mouth and inserted his fingers into her vagina. In addition, during a facility interview of other residents, it was determined that, at an earlier time, the AP kissed two other female residents and also rubbed the stomach of one of them. The AP is currently suspended.

Investigative Findings:
All employees and persons were interviewed in private as desired and given the Tennessen Statement.

The investigation included a review of resident #1's medical record as well as the medical records of three additional residents; staff schedules and assignments for 7/4/2009 through 7/7/2009; incident/accident reports for April, May and June 2009; personnel files of the AP and two additional staff members; the facility internal investigation and policies and procedures related to the Vulnerable Adults Act (VAA) and abuse/maltreatment. Resident #1 was interviewed and described the sexual abuse to the investigators. Four additional residents were interviewed with no concerns noted. Observations of staff and resident interactions were made with no concerns identified.

Although the facility's internal investigation identified two additional residents who made allegations regarding the AP, neither resident #2 nor #3 stated the AP had inappropriate interactions with them to the investigators.

Medical Record:
A review of resident #1's medical record revealed diagnoses including convulsions, depressive disorder and dementia. Her Plan of Care dated 5/2009 documents that she is oriented to person and place and has impaired short term memory. Resident #1's Minimum Data Set (MDS) dated 5/29/2009 documents that resident #1 has a short term memory problem but, is able to recall the current season, the location of her room, staff names and faces and that she is in a nursing home. This documentation also establishes that she has no mood or behavior problems and requires assistance in all areas of activities of daily living (ADL's).

***Internal Investigation*:**
The facility's internal investigation regarding resident #1's allegations was reviewed and is consistent with the investigators findings.

During the course of the internal investigation, the facility identified two additional residents (residents #2 and #3) who reported inappropriate contact by employee (F)/nursing assistant/alleged perpetrator. Resident #2, who resides on the 2nd floor, told facility staff that the AP had kissed her on the mouth and hugged her over the weekend. A review of the schedule showed that the AP had worked on the 2nd floor and been assigned to care for resident #2 on 7/3/2009. Resident #3, who resides on the Garden Terrace unit, told facility staff that the AP had kissed her on the cheek and rubbed her stomach about a week ago.

Interviews:
Resident #1 was interviewed on 7/10/2009 at 8:48 a.m. and stated the following:

- She returned from an outing at about 9:00 p.m. on Monday night, 7/6/2009. She stated a man came in to help her to bed. She had seen him in the facility before but had never received cares from him. She described him as a black male with no hair, even teeth, average weight and wearing blue scrubs.
- She stated he started kissing her several times on the cheek and the mouth with a closed mouth. She thinks that he kissed her about four times, twice on the mouth. She stated "he then ran his hands down her legs" and "tickled her diaper and stuck his hands inside" and "tickled" her between the legs. She stated he felt around her vagina but did not insert his fingers inside of her. She stated she jerked his hand away and stated "we shouldn't be doing this." She stated that she could not have misinterpreted receiving incontinent perineal care because he had already changed her "diaper" before he put his hand inside of her clean "diaper" between her legs.
- She stated she was surprised by the AP's actions and thought "this can't be happening." She stated that the AP said he would see her tomorrow as he left the room.
- She stated the following morning she went to employee (G)/nurse and asked for employee (C)/administrative nurse. She was told that employee (C) was not there, so she left a note for her to come and talk with her. Towards the afternoon, she went to the area near employee (C)'s office to wait to talk with her because she knew he [the AP] worked the afternoon shift. She was then able to meet with employee (C) and tell her about the incident.
- She stated did not want to have a sexual assault examination at a hospital. She stated she talked it over with her surrogate decision maker and decided she did not want an exam.

Employee (C)/administrative nurse was interviewed on 7/10/2009 at 1:19 p.m. and stated the following:

- Resident #1 asked to speak with her on 7/7/2009 and told her that she didn't want to receive care again from the aide who had cared for her the evening before. Upon further questioning, resident #1 told her that she didn't like how this aide had touched her. She stated he kissed her mouth, kissed her cheek and brushed her arm and thigh. He then asked her how old she was, she did not reply. She told employee (C) that he then put his hand down her diaper and moved his fingers around inside of her and tickled her. Employee (C) asked if he put his fingers inside of her vagina and resident #1 stated yes. Resident #1 then said she pushed his hand away and said she didn't think he should do that. Resident #1 told her that the AP had already completed perineal cares and changed her incontinent pad prior to him placing his hands inside of her incontinent pad. She stated that when he changed her pad, it was like everyone else does. It was after she was cleaned and in bed that he put his hands inside of her pad and touched her inappropriately.
- Resident #1 didn't know the name of the aide who had cared for her but gave employee (C) a physical description. She told her that he was a black male of medium build, bald with straight teeth. She stated he had on blue scrubs. Employee (C) stated that the AP was the only person working on the unit on the evening shift of 7/6/2009 who fit the physical description given by resident #1. She stated that resident #1 is very familiar with all of the other staff who worked on 7/6/2009, as they are all regularly scheduled on that unit.
- Employee (C) went to the nursing station to review the assignment sheets from 7/6/2009, the evening before, and saw that a female nursing assistant, employee (H), was assigned to resident #1. When employee (C) asked employee (H) if she had assisted resident #1 to bed the previous evening, employee (H) told her that the AP had assisted resident #1 to bed. When asked why, employee (H) stated she did not know, he just did it.
- She interviewed the AP on 7/7/2009 with employee (A)/administrative staff. She asked the AP who he put to bed the evening before. He told her he didn't know. She asked if he assisted any residents to bed who were not on his assignment sheet. He didn't respond. She asked if he assisted resident #1 to bed and he responded yes. When asked why he assisted resident #1 to bed when she wasn't assigned to him he stated that her call light was on and he couldn't believe that she was still up at 9:00 p.m. She asked the AP if he had ever kissed resident #1, he stated no. She asked the AP if he had placed his hand inside of resident #1's incontinent pad, he stated no. She asked the AP if he had placed his fingers inside of resident #1's vagina, he stated no. She asked the AP what color scrubs he had been wearing on 7/6/2009, he stated green.
- The AP was immediately placed on suspension pending the outcome of the investigation.
- She assisted employee (J)/administrative nurse in a visual examination of resident #1's vaginal area. She saw no redness, no tearing, no abrasions and no scraping. She stated that resident #1 had no complaints or signs of pain or discomfort during the exam. She asked resident #1 if she wanted to go to the emergency room for a sexual assault examination. She stated that resident #1 is very private and wanted to discuss it with individual (O)/decision maker before deciding. Upon discussion with individual (O), resident #1 decided not to have any further examination.
- She interviewed resident #1 two or three times and her recall of the incident was consistent each time.

Employee (E)/social worker was interviewed on 7/10/2009 at 12:55 p.m. and stated the following:

- She interviewed other residents on the 2nd floor and Garden Terrace unit after learning of the allegation. She stated that when she spoke with the residents she asked general questions such as "do you know [the AP]" and "has [the AP] cared for you." She found two additional residents who reported concerns about the AP during the course of her interviews.

- Resident #2, who resides on the 2nd floor, expressed that the AP had kissed her on the mouth over the weekend. She stated nothing happened beyond the kiss and she didn't say anything because he seemed so nice that she didn't want to tell on him. She expressed that she was not upset or afraid. Employee (E) stated that if resident #2 is upset "you will know." She stated that most of the time resident #2 is reliable.
- Resident #3, who resides on the Garden Terrace unit, expressed that the AP kissed her cheeks and rubbed her stomach a week ago. She indicated that he rubbed her stomach in the area of her belly button. She stated she told him to stop and he did. Employee (E) stated that resident #3 remembers staff names and faces. She stated that resident #3 has reported concerns about staff members making her fall and has stated "I lied" in the past. Resident #3 has never made concerns about inappropriate touching. She stated when she was interviewing resident #3 she did tell resident #3 that it was very important that she tell the truth and asked her if she was telling the truth. She stated that resident #3 said yes and employee (E) finds her credible.

Employee (B)/administrative nurse was interviewed on 7/10/2009 at 9:17 a.m. and stated the following:

- She reviewed behavior logs for all residents on the Garden Terrace unit, where the AP usually worked. She found no increased incidence of behavior issues during the AP's work shifts.
- She reviewed accident/incident reports for any abnormal or defensive injuries and found none.
- She interviewed employee (D)/administrative nurse on the AP's regularly scheduled unit who expressed concerns with the AP's performance including communication and teamwork. Employee (D) stated it was unusual to think the AP would volunteer to help provide cares for a resident who was not on his assignment.
- She interviewed employee's (K), (L) and (M) who worked the night shift on 7/6/2009 and was told there were no concerns expressed to any of them by resident #1. They noted no blood in her pad and said she appeared to be her normal self.
- She reviewed the staff assignments and determined that the AP did work with resident #2 on 7/3/2009, as reported by resident #2 to employee (E).

Employee (G)/licensed nurse was interviewed on 7/10/2009 at 12:40 p.m. and stated the following:

- Resident #1 approached her just before breakfast and asked if employee (C) was in. When she was told that employee (C) was not in, she asked to leave a message for her to stop in to see her. She asked employee (G) who had cared for her the night before but did not say anything specific about him.
- She stated that resident #1 is alert and oriented to person, place and time. She stated that she is a good historian and has never known resident #1 to have concerns about staff before.

Employee (H)/NA was interviewed on 7/10/2009 at 2:48 p.m. and stated the following:

- She worked the evening of 7/6/2009 and was assigned to care for resident #1. Resident #1 had gone for a facility outing and got back late. When resident #1 returned, employee (H) was caring for another resident. When she had finished and went to assist resident #1, another resident was found on the floor near his bed, so she assisted the nurse with him. The AP came in while she was assisting the resident on the floor and asked her who had resident #1. She stated "me." He stated that he had provided cares for resident #1. She was unaware if resident #1's call light had been on. She stated she had worked with the AP before, but did not state how often that was. She stated this was the first time the AP ever got someone from her assignment ready for bed.

Employee (J)/administrative nurse was interviews on 7/15/2009 and stated the following:

- She completed a visual examination of resident #1's vaginal area with employee (C), she was uncertain of the date. She saw no bruising, no redness, no scratches, no blood and no discharge in resident #1's vaginal area. She also examined resident #1's thighs and buttocks and did not see any marks. Resident #1 did not complain of pain during the examination.

Employee's (K)/NA and (L)/licensed nurse were interviewed and stated the following:

- They worked the 10:30 p.m. – 7:00 a.m. shift beginning on 7/6/2009 and ending the morning of 7/7/2009.
- Employee (K) provided incontinent care for resident #1 and saw no signs of injury or abnormality during perineal care.
- Employee (L) stated that resident #1 had no complaints on this night.
- Both employee (K) and (L) indicated that resident #1 appeared to be her usual self with no sign of anything unusual. She didn't complain or report anything out of the ordinary to either of them.

Employee (M) was interviewed and stated he worked 10:30 p.m. – 7:00 a.m. beginning on 7/6/2009 and ending the morning of 7/7/2009 and did not see resident #1 during his shift.

The AP was interviewed on 8/24/2009 at 10:41 a.m. with an interpreter present and stated the following:

- He stated he answered resident #1's call light and assisted her to bed since she was still up in her wheelchair. He stated he assisted her with incontinent care and cleaned her. He stated it was the first time he worked with resident #1.
- He stated he did not kiss resident #1 on the cheek or mouth; he stated he did not rub resident #1's thigh; he stated he did not put his hand between resident #1's legs or insert his fingers into her vagina. He stated that maybe she misinterpreted his cleaning her peri-area.
- He stated he does not recall who resident #2 is but does remember working on the 2nd floor on 7/3/2009. He stated he did not kiss resident #2 on the mouth.
- He stated he did not kiss resident #3 on the cheek. He stated that resident #3 does recognize him and calls him by name. He states he has hugged resident #3.
- He stated that he always treats resident in a loving way. He described a loving way as hugging, greeting them in a good way and taking care of them in a good way.

Personnel Files:

A review of the AP's personnel file revealed the following:

- The AP signed a document titled Extendicare Policy Prohibiting Abuse, Neglect, Misappropriation on 12/24/2008.
- The AP signed an acknowledgment of receipt of the Minnesota Nursing Home Resident's Bill of Rights and Vulnerable Adult Rules on 12/29/2008.
- A form titled Employee Performance and Development Review dated 7/8/2009 documents that the AP has strained relations with other staff and supervisors. It documents areas for improvement including: relations with coworkers; respect for supervisor and resident rights and safety.
- The AP had a cleared background study indicating he could provide direct contact services.

Police Report:

The police report from individual (P)/Police Agent reflects that the case will be referred for charges of criminal sexual conduct in the third degree.

Conclusion:
As defined by federal regulatory requirements at 42 CFR 483.13(b), and the current statutory definition specified within Minnesota Statutes §626.5572, the preponderance of evidence indicates that **sexual abuse did occur** in connection with the allegation that the AP kissed resident #1 on the mouth and inserted his fingers into her vagina.

Resident #1 is alert and recognizes staff names and faces. She gave a consistent account of the sexual abuse including kissing on the cheek and mouth, rubbing of her thigh and insertion of fingers in her vaginal area to multiple interviewers on different dates. The AP was the only staff member working on 7/6/2009 who fit the physical description given by resident #1. The AP stated he did provide evening cares for resident #1 on 7/6/2009.

The "mitigating factors" in Minnesota Statutes, §626.557, subdivision 9c (c) were considered and it was determined that the perpetrator is responsible for the abuse. The AP received training regarding abuse, the bill or rights and the Vulnerable Adults Act (VAA). The AP will be notified of the right to request reconsideration and/or appeal the maltreatment finding.

Since the allegation of abuse by an identified employee is substantiated, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements in State law. The employee will be notified of the right to request reconsideration and a hearing to challenge these findings.

xc: Division of Compliance Monitoring - Licensing & Certification
St. Louis Park City Police Department: attention Agent Matt Reilly
Hennepin County Attorney
St. Louis Park City Attorney

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245187	A. BUILDING ______ B. WING ______	C 07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEXAS TERRACE CARE CENTER	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

(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) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate complaint H5187039. No deficiencies are issued.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.