Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H5316043M **Date Concluded:** June 3, 2022

Name, Address, and County of Licensee Investigated:
New Richland Care Center
312 1st Street Northeast
New Richland, MN 56072
Waseca County

Facility Type: Nursing Home **Evaluator's Name:** Peggy Boeck, RN
Special Investigator

Finding: Substantiated, individual responsibility

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.

Allegation(s):
The alleged perpetrator (AP) sexually abused a resident. The AP had sexual contact with the resident when the AP kissed the resident on the mouth and allowed the resident to touch the AP's breasts over her clothing.

Investigative Findings and Conclusion:
Sexual abuse was substantiated. The AP was responsible for the maltreatment. Two separate witnesses observed the AP engaged in sexual contact with the resident. The first witness observed the AP leaning over the resident in his wheelchair, allowing the resident to touch the AP's breasts. The second witness observed the AP in the resident's room with her arms around the resident, kissing the resident on the mouth. Psychological harm occurred when the resident experienced increased worry and fears related to the incident.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator reviewed the AP's personnel and training

records, the AP's Facebook public posts, resident records, facility documents, policies, and procedures related to maltreatment of vulnerable adults and code of conduct.

The resident lived at the facility for several years due to diagnoses including Parkinson's Disease and dementia. Although the resident had a history of hallucinations, an assessment determined the resident was cognitively intact. The resident received cares that included assistance of two staff for toileting, assistance of two staff for bed mobility, assistance of one staff for bathing, and assistance of two staff for transfers.

According to a facility incident report, one evening an unlicensed staff (#1) knocked and walked into the resident's room to offer a snack. The unlicensed staff (#1) saw the AP leaning over the resident, who was in his wheelchair. The unlicensed staff (#1) saw the resident's hand on the AP's breast, so she quickly stepped back and asked the resident what he wanted for a snack.

During an interview, the unlicensed staff (#1) stated when she entered the resident's room the AP was standing in front of the resident, who was in his wheelchair. The unlicensed staff (#1) stated she saw the resident's left hand on the AP's right breast. The unlicensed staff (#1) stated when the AP heard her ask the resident about a snack, the AP pulled away from the resident, and told the resident she (the AP) would be back later to help the resident bathe. The unlicensed staff (#1) reported the incident to a facility social worker the next day.

During an interview, a second unlicensed staff (#2) stated she entered the resident's room the same evening and saw the AP with her arms around the resident, kissing the resident on the mouth. The unlicensed staff (#2) reported her observation to a nurse, who reported the incident to a facility social worker.

During an interview, the social worker stated she contacted administrative staff and participated in the investigation based on the two staff observations. The social worker stated she interviewed multiple staff and residents about the AP's interactions with residents. The social worker stated the resident confirmed there had been kissing between he and the AP, and that they were close. The resident told the social worker he and the AP were good friends and did not want her "crucified" for her behavior. The social worker also stated she received a report two months prior to the incident from a third unlicensed staff (#3). During that incident the unlicensed staff (#3) observed the AP kneeling on the resident's bed and giving the resident a hug that lasted over five minutes.

During an interview, unlicensed staff (#3) stated she observed the AP on the resident's bed hugging the resident with both arms around him. Unlicensed staff (#3) stated they must have leaned on the call light button, so she (unlicensed staff #3) went in the resident's room and that was when she observed the hugging. The unlicensed staff (#3) stepped out and watched the AP come out of the resident's room between five and ten minutes later, which she felt was suspicious.

During interviews, multiple unlicensed staff stated the AP had a history of leaving her scheduled area to go to the resident's room for up to an hour when not assigned. Two of the unlicensed staff stated the AP often volunteered to give the resident his bath, when not assigned to the resident. Several unlicensed staff reported their concerns to the nurse, who e-mailed administrative staff two weeks before the incident.

During an interview, an administrative staff stated the resident told her during the investigation that he had a close relationship with the AP, they did some kissing, and he did not want her to get into trouble. The administrative staff stated the facility investigation included resident interviews, with no resident expressing concerns about the AP. The administrative staff also stated that during the previous allegation investigation, the resident denied a relationship with the AP, so the facility did not pursue it any further.

During an interview, a family member stated the resident had significant emotional decline since the incident, including ongoing fear of arrest for participating in a relationship with the AP. The family member expressed concern about public posts she saw on the AP's social media page. The AP often posted obituaries of residents and once wrote that she would "miss our Monday night date nights" which the family member feared meant there could be other victims.

During an interview the AP stated she did not recall the resident touching her breast. The AP stated she would never kiss a resident on the mouth. The AP stated the resident had a big bed, so when she hugged him, she would "have to get in" the resident's bed. The AP stated she liked the resident and considered him a friend.

In conclusion, sexual abuse was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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;
(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; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(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: No, at the request of family.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The AP no longer works at the facility.
The facility provided retraining to all staff on sexual abuse and reporting maltreatment of vulnerable adults.

Action taken by the Minnesota Department of Health:
No further action taken.

cc:
The Office of Ombudsman for Long-Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Waseca County Attorney
Waseca County Sheriff's Office
New Richland Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00748	A. BUILDING: _____ B. WING _____	C 06/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW RICHLAND CARE CENTER	**312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072**

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H5316043M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	2 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the	

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2 000	Continued From page 1 #H5316043M, tag identification 1850. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000	far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the evaluators findings are the Suggested Method of Correction and the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN, WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints,	21850		6/10/22

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21850	Continued From page 2 except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was abused. Findings include: On May 31, 2022, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	21850	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	