Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HG010036M
Compliance #: HG010033C

Date Concluded: September 27, 2022

Name, Address, and County of Licensee Investigated:

Harry Meyering Center Inc.
109 Homestead Road
Mankato, MN 56001
Blue Earth County

Facility Type: Intermediate Care Facility (ICF)

Evaluator's Name: Erin Johnson-Crosby, 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.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) abused the client when the AP called the client names, gave the client the "finger" and told the client she did not like her.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP denied the allegations however there were witnesses to the verbal abuse and the client's allegations remained consistent.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigation included review of Minnesota Department of Health survey notes and records, facility internal investigation and the resident record.

The client resided in an Immediate Care Facility (ICF). The client's diagnoses included mild intellectual disability, borderline personality disorder (mental health disorder characterized by unstable emotional dysregulation) and bipolar disorder. The client's Intensive Support Self-Management Assessment (ISMA) indicated the client was able to transfer independently to her walker or wheelchair and the client may also request staff assistance. The client had a history of displaying attention seeking behaviors, throwing things at staff when upset and using inappropriate and offensive comments.

The client's individual abuse prevention plan (IAPP) indicated the client was susceptible to abuse related to the inability to identify potentially dangerous situations, lack of community orientation skill, inappropriate interactions with others, inability to deal with verbally/physically aggressive persons, likely to seek or cooperate in an abusive situation, inability to be assertive and verbal aggression to others. The assessment further indicated the client had cognitive deficits and may not report abuse and if staff see or hear verbal or physical abuse the staff were directed to intervene. In addition, the assessment included that if the client reports any allegations of abuse, staff would investigate the allegations.

The Minnesota Adult Abuse Reporting Center (MAARC) report indicated the alleged perpetrator (AP) called the client names, gave the client the "finger" and told the client the AP did not like her. The client stated she could not handle the AP's behavior anymore and needed to get out of the facility.

An email exchange between the facility program director and the client's guardian indicated the client called the guardian to report concerns about a specific staff person (AP). The client also reported the AP did not like her and disrespected her. The client reported the AP called her names, told her she did not like her and gave her the finger.

The facility's internal investigation indicated the client told staff the AP gave her the finger and called her every name in the book but could not remember what names. The client stated she was not doing anything, and the AP would come in and start swearing at her. The client stated this happened more than once. Director Support Personnel (DSP)-A stated the client asked her not to let the AP care for her because the AP would swear at her and give her the finger. DSP-A did not report this because she did not know if it was truthful until the client continued to bring up the incident. DSP-B reported she heard staff talking about the AP swearing at the client and flipping her off but did not know if it was true, so she did not report it. DSP-C stated the client reported to her that the AP would yell at her even if she did not do anything wrong and cooperated with cares. DSP-D stated she heard the AP get into heated arguments with the client where the AP would tell the client to "shut up". The AP denied swearing at the resident or giving the client "the finger." The internal investigation concluded four staff were aware of the abuse allegation reported by the client.

During an interview, DSP-A stated the AP would tell the client to “shut the hell up” and say the “f” word when the AP thought they were alone. The DSP stated she heard the AP screaming at the client, yelling and swearing at her. The DSP stated this happened between 12 to 20 times and the client told DSP-A she feared the AP.

During an interview, the client’s family member (FM) stated the client informed her the AP swore at her and gave her the finger more than one time and the FM reported the information to the program director.

During an interview, facility administrative staff stated the client had a history of making accusations toward staff to get staff in trouble or fired, but after completion of the internal investigation, it was determined that the allegation had occurred.

The AP is no longer employed by the facility.

The investigator placed multiple calls in attempts to interview DSP-B, C and D, but calls were not returned.

A subpoena was sent to the AP but was returned to sender.

In conclusion, 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;

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No

Action taken by facility:
The AP is no longer employed by the facility. The facility completed education regarding Vulnerable Adults, and Client Bill of Rights.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, 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 under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Blue Earth County Attorney
Mankato City Attorney
Mankato Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01008	A. BUILDING: _____ B. WING _____	C 08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY MEYERING CTR INC	109 HOMESTEAD ROAD MANKATO, MN 56001

(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
5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, 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 or MN Statute indicated below. When a rule or statute 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. The Minnesota Department of Health investigated an allegation of maltreatment, complaint #HG010036M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders are issued for #HG010036M, tag identification 0700. The facility has agreed to participate in the	5 000		

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5 000	Continued From page 1 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.	5 000		
5 700	MN Statute 144.651 Subd. 14. RES. RIGHTS 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 nontherapeutic 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 nontherapeutic chemical and physical restraints, 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:	5 700		

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5 700	Continued From page 2 Based on observations, interviews, and document review, the facility failed to ensure one of one client reviewed (C1) was free from maltreatment. C1 was abused. Findings include: On September 15, 2022, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and 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.	5 700		