Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL20151009M
Compliance #: HL20151010C

Date Concluded: August 6, 2020

Name, Address, and County of Licensee Investigated:
Wesley Residence
5601 Grand Ave.
Duluth, MN 55807
St. Louis County

Facility Type: Home Care Provider

Investigator's Name: Kathie Siemsen, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:
An investigator from 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):
It is alleged: The alleged perpetrator (AP) sexually abused the client when she had sexual intercourse with the client.

Investigative Findings and Conclusion:
Abuse was substantiated. The AP was responsible for the maltreatment. The AP and the client went to the AP's apartment and had sexual intercourse while the AP worked for the facility.

The investigation included interviews with facility staff, including nursing staff, unlicensed staff and the client. In addition the investigator reviewed the client's medical records, employee records and facility policies.

The client's medical record included diagnoses of post-traumatic stress disorder, anxiety and hearing loss. The client's care plan indicated he was independent with all activities of daily living, received help with medication administration and used public transportation. The client's

abuse prevention plan indicated he was at risk of being abused, wandered in and out of the facility, but had the physician's approval to do so.

The facility's investigation indicated unlicensed personnel (ULP)-D reported to the housing manager the client told her he took a bus with the AP to her apartment, had sexual intercourse with her and the AP paid for a cab ride for him to return to the facility. ULP-D reported the client had told her the incident happened approximately one month prior. The nurse and the housing manager investigated the incident and interviewed staff.

The client reported he told ULP-C about two weeks prior. The client reported it was a one-time incident and believed it was okay because it did not happen at the facility. The client stated he had been texting and Facebook (social media) messaging the AP and discussed having sex the day prior to the incident. The client stated him and the AP left the facility at approximately 5:45 p.m. with the intention to have sex. He said he went with the AP back to her apartment, had sex and she paid his cab fare for him to return to the facility at approximately 2:00 a.m.

The facility placed the AP on leave pending an investigation, however the AP failed to participate in an interview with the facility. The AP was no longer employed by the facility.

During an interview with ULP-D she stated the same facts as the investigation. ULP-D stated she felt the client was a reliable reporter and was truthful.

During an interview with ULP-C, she stated the client did report to her he had sex with the AP, but she did not believe him and did not report the incident. ULP-C stated she had vulnerable adult training, but did not remember it.

During an interview with the nurse, she stated ULP-C reported she did not report in fear of losing her friendship with the AP. The nurse stated all staff are trained every year on abuse. The nurse stated she was unaware of the client making false allegations and stated she believes the client “100%” that the incident between the client and the AP took place. The nurse stated the client had left numerous nights the AP worked and returned in the middle of the night.

During an interview, the client stated it was both his and the AP’s idea to go to the AP's apartment. The client knew a staff member and a resident cannot get sexually involved, but thought it would be okay since they did not have sex at the facility. The client stated him and the AP took a bus to her apartment together, had sexual intercourse and she paid for a cab for him to return to the facility. The client stated the incident happened about a month prior and stated he reported first to ULP-C. The client confirmed the identity of the AP.

During an interview with the AP, she denied having a relationship with the client and denied having sexual intercourse with the client. The AP added that approximately a week prior the client stood outside her house. The AP asked the client why and how he got there and stated he

told her he took the bus and was there for a visit. The AP stated she had previously given the client the name of the street she lived on and described where she lived to him.

In conclusion, abuse was substantiated.

Abuse: Minnesota Statutes section 626.5572, subdivision 2
"Abuse" means:
(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: No, the client declined notification of family.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated the incident and the AP was no longer employed by the facility. Staff had vulnerable adult maltreatment and reporting training.

Action taken by the Minnesota Department of Health:
The Minnesota Department of Health made the recommendation to disqualify the alleged perpetrator to the Department of Human Services.

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, or call 651-201-4890 to be provided a copy via mail or email. 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:
Health Regulation Division – Home Care and Assisted Living Program
The Office of Ombudsman for Long-Term Care
St. Louis County Attorney
City of Duluth Attorney
Duluth Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20151	A. BUILDING: _____ B. WING _____	C 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY RESIDENCE OF DULUTH	5601 GRAND AVE DULUTH, MN 55807

(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 ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On July 16, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL20151009M, #HL20151010C. At the time of the investigation, there were 38 clients receiving services under the comprehensive license. The following correction orders are issued for #HL20151009M, #HL20151010C tag identification 0325, 0805, 2015.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2)	
0 325 SS=G	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or	0 325		

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0 325	Continued From page 1 in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure 1 of 3 clients (C1) reviewed was free from maltreatment when a dietary staff (DS) had sex with C1. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Review of C1's medical record included diagnoses of post-traumatic stress disorder, anxiety and hearing loss. C1's care plan dated July 8, 2020, indicated C1 was independent with all activities of daily living, received help with medication administration and used public transportation. C1's Individual Abuse Prevention Plan dated July 8, 2020, indicated C1 was at risk of being abused, wandered in and out of the facility and had the physician's approval to do so. The facility's investigation indicated unlicensed	0 325		

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0 325	Continued From page 2 personnel (ULP)-D reported to the housing manager (HM)-B that C1 told ULP-D he took a bus with DS-E to her apartment and C1 had sex with DS-E. DS-E then paid for a cab for C1 to return to the facility. ULP-D found out when she talked to C1 during the night shift the night before she reported it to the HM-B. HM-B and registered nurse (RN)-A interviewed C1. C1 stated he took a bus with DS-E to her apartment on either May 29, 2020, or June 5, 2020, and they had sex. It was a one time thing and C1 believed it was okay because it was not at the facility. C1 stated he left the facility on either May 29, 2020, or June 5, 2020, at approximately 5:45 p.m. and returned at 2:00 a.m. by cab of which DS-E paid for. C1 added he had been texting and Facebook (social media) messaging DS-E. C1 and DS-E had discussed having sex prior to the day he left with her and left with DS-E that day with the intention of having sex. C1 stated he did not say no as he wanted to have sex with DS-E. C1 knew it was wrong but since they were not at the facility and they both wanted to have sex then thought it would be okay. C1 verified he told ULP-C about two weeks ago but felt she did not believe it or want to believe it. RN-A and the HM-B met with ULP-C. ULP-C stated a couple of weeks ago C1 reported to her he took the bus with DS-E to DS-E's apartment. DS-E put on a black nightie, C1 and DS-E had sex and C1 took a cab of which DS-E paid for. ULP-C felt C1 was being truthful. ULP-C was asked why she did not come forward and make a report about the incident. ULP-C stated she did not want to get anyone in trouble and was fearful of termination. ULP-C stated she did not want to lose her friendship with DS-E because she would be mad at her for saying something. DS-E an ULP-C were placed on leave pending the investigation.	0 325		

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0 325	Continued From page 3 On July 1, 2020, at 10:00 a.m. the human resources manager (HRM) went to the facility to meet with DS-E. DS-E did not show, call or return a call. DS-E no longer works for the licensee. During an interview on July 16, 2020, at 11:18 a.m., C1 was interviewed. C1 stated it was both C1's and DS-E's idea to go to DS-E's apartment. C1 thought it would be okay and knew a staff and resident cannot get sexually involved so C1 would go to DS-E's place. C1 was at DS-E's apartment with the doors locked and no other residents around so C1 thought it was okay. C1 verified who DS-E was. C1 and DS-E left the facility together, took the bus to DS-E's apartment, spent the evening together and DS-E paid for a cab for C1 to return to the facility. C1 stated this happened about a month ago. C1 stated he had told ULP-C about going to DS-E's apartment a couple of weeks prior. C1 stated DS-E also invited C1 and another resident to her apartment for dinner. During an interview on July 16, 2020 at 12:06 p.m., RN-A stated the HM-B reported the incident to her after having a meeting with ULP-D. This was the first time RN-A had heard of anything between C1 and DS-E. DS-E worked 10:00 a.m. until 6:00 p.m. ULP-C and DS-E were friends and although ULP-C knew about it but she did not report the incident. ULP-C has had training on being a mandated reporter. RN-A further stated no one was able to interview the AP. RN-A stated staff are trained every year on abuse. During an interview on July 16, 2020, at 2:19 p.m., HM-D stated ULP-D, reported during her night shift C1 told her the week before that C1 and DS-E had sex.	0 325		

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0 325	Continued From page 4 During an interview on July 17, 2020 at 3:47 p.m., ULP-D was interviewed. ULP-D stated she has worked at the facility just over four years. ULP-D stated C1 had approached her and told ULP-D that he had gone home with DS-E on the bus, they had sexual intercourse at her apartment and DS-E paid for a cab for C1 to return to the facility. C1 told ULP-D on June 29, 2020 and ULP-D reported it in the morning of June 30, 2020 to HM-B. ULP-D felt C1 was a reliable source and reporter because C1 put his head down and was more serious about this than what he usually jokes about with staff. During a follow up interview with RN-A on August 3, 2020, at 10:49 a.m., RN-A stated she was not aware of C1 making any false accusations about the staff. RN-A stated she believes "100%, without a doubt" the incident between C1 and DS-E happened. RN-A was asked if there was any reason DS-E would deny the allegation. RN-A stated she was sure DS-E would deny the allegation and DS-E would not come in and talk to RN-A. C1 had left numerous nights while DS-E was working and returned in the middle of night. On August 3, 2020, at 2:35 p.m., a follow up interview was completed with ULP-D. ULP-D stated she believed what C1 told her about going to DS-E's house and having sex with DS-E to be true. The facility's Maltreatment of Vulnerable Adults Reporting policy dated February 2017, indicated employees would report any suspected maltreatment of abuse. The policy described a vulnerable adult as any person 18 years or older who was a resident of the facility. The policy's definition of abuse included any sexual contact or penetration between a facility staff person and a	0 325		

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0 325	Continued From page 5 resident of the facility. If an employee knows or suspects that a vulnerable adult has been maltreated, the employee must report it immediately. TIME PERIOD OF CORRECTION: Seven (7) days	0 325		
0 805 SS=D	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors Subd. 6.Reporting maltreatment of vulnerable adults and minors. (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care provider must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to report maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) immediately, but no longer than 24 hours for 1 of 1 clients (C1) reviewed when an unlicensed personnel (ULP) failed to report C1 was sexually abused. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a	0 805		

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0 805	Continued From page 6 limited number of staff are involved or the situation has occurred only occasionally). The findings include: Review of C1's medical record included diagnoses of post-traumatic stress disorder, anxiety and hearing loss. C1's care plan dated July 8, 2020, indicated C1 was independent with all activities of daily living, received help with medication administration and used public transportation. C1's Individual Abuse Prevention Plan dated July 8, 2020, indicated C1 was at risk of being abused, wandered in and out of the facility and had the physician's approval to do so. The facility's investigation indicated unlicensed personnel (ULP)-D reported to the housing manager (HM)-B that C1 told ULP-D he took a bus with DS-E to her apartment and C1 had sex with DS-E. DS-E then paid for a cab for C1 to return to the facility. ULP-D found out when she talked to C1 during the night shift the night before she reported it to the HM-B. HM-B and registered nurse (RN)-A interviewed C1. C1 stated he took a bus with DS-E to her apartment on either May 29, 2020, or June 5, 2020, and they had sex. It was a one time thing and C1 believed it was okay because it was not at the facility. C1 stated he left the facility on either May 29, 2020, or June 5, 2020, at approximately 5:45 p.m. and returned at 2:00 a.m. by cab of which DS-E paid for. C1 added he had been texting and Facebook (social media) messaging DS-E. C1 and DS-E had discussed having sex prior to the day he left with her and left with DS-E that day with the intention of having sex. C1 stated he did not say no as he wanted to have sex with DS-E. C1 knew it was wrong but since they were not at the facility and they both wanted to have sex then thought it	0 805		

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0 805	Continued From page 7 would be okay. C1 verified he told ULP-C about two weeks ago but felt she did not believe it or want to believe it. RN-A and the HM-B met with ULP-C. ULP-C stated a couple of weeks ago C1 reported to her he took the bus with DS-E to DS-E's apartment. DS-E put on a black nightie, C1 and DS-E had sex and C1 took a cab of which DS-E paid for. ULP-C felt C1 was being truthful. ULP-C was asked why she did not come forward and make a report about the incident. ULP-C stated she did not want to get anyone in trouble and was fearful of termination. ULP-C stated she did not want to lose her friendship with DS-E because she would be mad at her for saying something. DS-E an ULP-C were placed on leave pending the investigation. During an interview on July 16, 2020, at 11:18 a.m., C1 was interviewed. C1 stated it was both C1's and DS-E's idea to go to DS-E's apartment. C1 thought it would be okay and knew a staff and resident cannot get sexually involved so C1 would go to DS-E's place. C1 was at DS-E's apartment with the doors locked and no other residents around so C1 thought it was okay. C1 verified who DS-E was. C1 and DS-E left the facility together, took the bus to DS-E's apartment, spent the evening together and DS-E paid for a cab for C1 to return to the facility. C1 stated this happened about a month ago. C1 stated he had told ULP-C about going to DS-E's apartment a couple of weeks prior. C1 stated DS-E also invited C1 and another resident to her apartment for dinner. During an interview on July 16, 2020 at 12:06 p.m., RN-A stated the HM-B reported the incident to her after having a meeting with ULP-D. This was the first time RN-A had heard of anything between C1 and DS-E. DS-E worked 10:00 a.m.	0 805		

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0 805	Continued From page 8 until 6:00 p.m. ULP-C and DS-E were friends and although ULP-C knew about it but she did not report the incident. ULP-C has had training on being a mandated reporter. RN-A further stated no one was able to interview the AP. RN-A stated staff are trained every year on abuse. During an interview on July 16, 2020, at 2:19 p.m., HM-D stated ULP-D, reported during her night shift C1 told her the week before that C1 and DS-E had sex. During an interview on July 17, 2020 at 3:47 p.m., ULP-D was interviewed. ULP-D stated she has worked at the facility just over four years. ULP-D stated C1 had approached her and told ULP-D that he had gone home with DS-E on the bus, they had sexual intercourse at her apartment and DS-E paid for a cab for C1 to return to the facility. C1 told ULP-D on June 29, 2020 and ULP-D reported it in the morning of June 30, 2020 to HM-B. ULP-D felt C1 was a reliable source and reporter because C1 put his head down and was more serious about this than what he usually jokes about with staff. During an interview on July 23, 2020, at 2:05 p.m., ULP-C stated she had worked at the facility for the past 20 years. ULP-C stated she did not believe it because it was coming from C1 and no one would believe her. C1 told ULP-C was that he got on the bus with DS-E went to the DS-E's house and had sex. ULP-C stated she had training on when and what to report for possible abuse but had forgotten about it. The facility's Maltreatment of Vulnerable Adults Reporting policy dated February 2017, indicated employees would report any suspected maltreatment of abuse. The policy described a	0 805		

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0 805	Continued From page 9 vulnerable adult as any person 18 years or older who was a resident of the facility. The policy's definition of abuse included any sexual contact or penetration between a facility staff person and a resident of the facility. If an employee knows or suspects that a vulnerable adult has been maltreated, the employee must report it immediately. TIME PERIOD OF CORRECTION: Seven (7) Days	0 805		
02015 SS=D	626.557, Subd. 3 Timing of Report Subd. 3.Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as	02015		

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	H20151	A. BUILDING: _____ B. WING _____	C 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY RESIDENCE OF DULUTH	5601 GRAND AVE DULUTH, MN 55807

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02015	Continued From page 10 described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to report maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) immediately, but no longer than 24 hours for 1 of 1 clients (C1) reviewed when an unlicensed personnel (ULP) failed to report C1 was sexually abused.	02015		

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02015	Continued From page 11 This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Review of C1's medical record included diagnoses of post-traumatic stress disorder, anxiety and hearing loss. C1's care plan dated July 8, 2020, indicated C1 was independent with all activities of daily living, received help with medication administration and used public transportation. C1's Individual Abuse Prevention Plan dated July 8, 2020, indicated C1 was at risk of being abused, wandered in and out of the facility and had the physician's approval to do so. The facility's investigation indicated unlicensed personnel (ULP)-D reported to the housing manager (HM)-B that C1 told ULP-D he took a bus with DS-E to her apartment and C1 had sex with DS-E. DS-E then paid for a cab for C1 to return to the facility. ULP-D found out when she talked to C1 during the night shift the night before she reported it to the HM-B. HM-B and registered nurse (RN)-A interviewed C1. C1 stated he took a bus with DS-E to her apartment on either May 29, 2020, or June 5, 2020, and they had sex. It was a one time thing and C1 believed it was okay because it was not at the facility. C1 stated he left the facility on either May 29, 2020, or June 5, 2020, at approximately 5:45 p.m. and returned at 2:00 a.m. by cab of which DS-E paid for. C1	02015		

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02015	Continued From page 12 added he had been texting and Facebook (social media) messaging DS-E. C1 and DS-E had discussed having sex prior to the day he left with her and left with DS-E that day with the intention of having sex. C1 stated he did not say no as he wanted to have sex with DS-E. C1 knew it was wrong but since they were not at the facility and they both wanted to have sex then thought it would be okay. C1 verified he told ULP-C about two weeks ago but felt she did not believe it or want to believe it. RN-A and the HM-B met with ULP-C. ULP-C stated a couple of weeks ago C1 reported to her he took the bus with DS-E to DS-E's apartment. DS-E put on a black nightie, C1 and DS-E had sex and C1 took a cab of which DS-E paid for. ULP-C felt C1 was being truthful. ULP-C was asked why she did not come forward and make a report about the incident. ULP-C stated she did not want to get anyone in trouble and was fearful of termination. ULP-C stated she did not want to lose her friendship with DS-E because she would be mad at her for saying something. DS-E an ULP-C were placed on leave pending the investigation. During an interview on July 16, 2020, at 11:18 a.m., C1 was interviewed. C1 stated it was both C1's and DS-E's idea to go to DS-E's apartment. C1 thought it would be okay and knew a staff and resident cannot get sexually involved so C1 would go to DS-E's place. C1 was at DS-E's apartment with the doors locked and no other residents around so C1 thought it was okay. C1 verified who DS-E was. C1 and DS-E left the facility together, took the bus to DS-E's apartment, spent the evening together and DS-E paid for a cab for C1 to return to the facility. C1 stated this happened about a month ago. C1 stated he had told ULP-C about going to DS-E's apartment a couple of weeks prior. C1 stated DS-E also	02015		

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02015	Continued From page 13 invited C1 and another resident to her apartment for dinner. During an interview on July 16, 2020 at 12:06 p.m., RN-A stated the HM-B reported the incident to her after having a meeting with ULP-D. This was the first time RN-A had heard of anything between C1 and DS-E. DS-E worked 10:00 a.m. until 6:00 p.m. ULP-C and DS-E were friends and although ULP-C knew about it but she did not report the incident. ULP-C has had training on being a mandated reporter. RN-A further stated no one was able to interview the AP. RN-A stated staff are trained every year on abuse. During an interview on July 16, 2020, at 2:19 p.m., HM-D stated ULP-D, reported during her night shift C1 told her the week before that C1 and DS-E had sex. During an interview on July 17, 2020 at 3:47 p.m., ULP-D was interviewed. ULP-D stated she has worked at the facility just over four years. ULP-D stated C1 had approached her and told ULP-D that he had gone home with DS-E on the bus, they had sexual intercourse at her apartment and DS-E paid for a cab for C1 to return to the facility. C1 told ULP-D on June 29, 2020 and ULP-D reported it in the morning of June 30, 2020 to HM-B. ULP-D felt C1 was a reliable source and reporter because C1 put his head down and was more serious about this than what he usually jokes about with staff. During an interview on July 23, 2020, at 2:05 p.m., ULP-C stated she had worked at the facility for the past 20 years. ULP-C stated she did not believe it because it was coming from C1 and no one would believe her. C1 told ULP-C was that he got on the bus with DS-E went to the DS-E's	02015		

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02015	Continued From page 14 house and had sex. ULP-C stated she had training on when and what to report for possible abuse but had forgotten about it. The facility's Maltreatment of Vulnerable Adults Reporting policy dated February 2017, indicated employees would report any suspected maltreatment of abuse. The policy described a vulnerable adult as any person 18 years or older who was a resident of the facility. The policy's definition of abuse included any sexual contact or penetration between a facility staff person and a resident of the facility. If an employee knows or suspects that a vulnerable adult has been maltreated, the employee must report it immediately. TIME PERIOD OF CORRECTION: Seven (7) Days	02015		