Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL20199072M
Compliance #: HL20199073C

Date Concluded: April 22, 2021

Name, Address, and County of Licensee Investigated:
Range Development Co of Chisholm Inc
PO Box 786
Hibbing MN 55746
St. Louis County

Name, Address, and County of Housing with Services location:
Hillcrest Terrace of Hibbing
1507 E 41st Street
Hibbing, MN 55746
St. Louis County

Facility Type: Home Care Provider

Investigator's Name: Jeri Gilb, RN, MSN, CNP
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):
It is alleged: The client was sexually abused when the alleged perpetrator (AP) engaged in a sexual physical relationship with the client.

Investigative Findings and Conclusion:
Based on a preponderance of evidence, sexual abuse was substantiated. The AP is responsible for the abuse. The client admitted to having a sexual relationship with the AP and there were multiple messages between the client and AP which indicated a sexual relationship.

The investigation included interviews with facility staff, including administrative and nursing staff. The client's medical records, facility policy and procedures, employee training records, internal investigation, and electronic communications between the client and AP were reviewed. In addition, law enforcement was contacted.

The client's medical records indicated diagnoses of bipolar disorder with anxiety, insomnia, and hypertension. The client was his own guardian and required services including medication management, housekeeping, and laundry services.

The facility nursing director stated the AP called and quit her job without providing a reason. Many days later, law enforcement (LE) contacted the facility regarding a report the AP made which claimed the client sexually assaulted her in his bedroom at the facility. The client admitted he had a consensual sexual relationship with the AP. The client provided electronic messages between the AP and himself as well as providing a date and time the AP spent the night with the client in his room in the facility; both indicating a consensual relationship. The facility reviewed the video cameras and verified the AP spent 3 hours in the client's room during the night shift when the client had no scheduled cares. The facility gave LE the camera footage and electronic messaging from their internal investigation. The client quit his job and had severe anxiety and fear after the AP reported the client sexually assaulted her.

Review of the LE report indicated the AP reported the sexual assault on a recorded message to the police department. On the recording, a male in the background can be heard telling the AP what to say to LE. The LE report indicated the AP did not work on the date or time she reported the client allegedly sexually assaulted her. The client provided electronic messaging between himself and the AP which discussed a consensual sexual physical relationship. The facility provided LE a video showing the AP entering the client's room for approximately 3 hours in the middle of the night on her scheduled night shift. The AP told LE she was in the client's room for three hours looking at his colorings.

In conclusion, based on a preponderance of evidence 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.
(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: No, Unable.
Family/Responsible Party interviewed: N/A.
Alleged Perpetrator interviewed: No. AP did not attend multiple different scheduled interviews.

Action taken by facility: No action necessary.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

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
St. Louis County
Hibbing Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20199	A. BUILDING: _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE OF CHISHOLM	624 SW THIRD STREET BOX 552 CHISHOLM, MN 55719

(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 April 22, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL20199073C/#HL20199072M. At the time of the survey, there were 40 clients receiving services under the comprehensive license. The following correction order is issued for #HL20199073C/#HL20199072M. tag identification 0325.	0 000	The Minnesota Department of Health documents 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the investigators' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for licensing order follow-ups. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
0 325	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 observations, interviews, and document review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 was abused when the alleged perpetrator engaged in a physical relationship with C1. Findings include: On April 22, 2021, the Minnesota Department of Health (MDH) issued a determination that abuse occurred. There was a preponderance of evidence that maltreatment occurred and the individual was responsible for maltreatment.	0 325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report for details.	