Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL28604027M
Compliance #: HL28604028C

Date Concluded: March 1, 2021
Date of Visit: February 18, 2021

Name, Address, and County of Licensee:
Summit Hill Senior Living
1824 Old Hudson Road
Saint Paul, MN 55119
Ramsey County

Facility Type: Home Care Provider

Investigator's Name:
Carrie Euerle MPH, MSN, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:
An unannounced visit was conducted to investigate 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 that sexual abuse occurred when a staff member/alleged perpetrator (AP) began kissing a client, touching a client's private area and leg and texting the client. In addition, the AP brought a bag of marijuana into the client's room and stated she smoked marijuana every day before work.

Investigative Findings and Conclusion:
Abuse was substantiated. The alleged perpetrator (AP) was responsible for the maltreatment. There is a preponderance of evidence that the AP initiated sexual contact with the client by touching the client's inner thigh and/or groin area with sexual intent.

The investigation included interviews with facility staff, including administrative staff, nursing and unlicensed staff. In addition, law enforcement was contacted. No observations were made

at the time of the onsite visit as the client was not at the facility at the time of the visit and the AP was no longer employed at the facility.

The client was admitted to the facility and received services from the facility which included medication administration. The client was independent with cares and was assessed by the facility to be alert, oriented, and able to appropriately communicate his needs.

The client reported to facility staff that the AP had inappropriately touched his private area and leg, kissed him and was texting him. In addition, the client reported the AP dropped a bag of marijuana in his room while passing his medications.

Upon learning of the incident, the facility immediately reported and began an investigation into the incident. The facility reviewed the text messages from the AP to the client, interviewed the client, reported the incident to police and interviewed the AP.

Upon the facility administration's interview with the AP, the AP denied the allegations however, immediately resigned her position.

The client was interviewed and stated the following:
The AP came to his room to bring his medications. The client indicated this was the first time he had worked with the AP. When the AP took out the client's medication from her pocket, the client stated a bag that appeared to be marijuana fell out of her pocket. The AP told the client she "gets high" every day before work. The client stated he told the AP she should not be bringing that to work and could get in trouble. The client denied the AP offered him marijuana. The AP then told the client she had a crush on him since the first time she saw him. The client stated the AP then began trying to kiss him on the cheeks and lips. The client turned away and the AP straddled his leg and began rubbing his inner thigh. The AP then asked the client to "take out his penis" and asked him if "he could get hard." The client then told the AP "No" and told the AP to leave his room.
The client stated the AP left his room but he later received "crazy" text messages from the AP that stated she was in love with the client and wanted to be with him. The AP later requested via text for the client to delete the messages.
The client stated he was shocked by the whole incident and he reported the incident so someone would take care of it. The client questioned if the AP had a background check completed, if she should have been able to be working in the position that she held, and how many others received this type of treatment from the AP. The client further reported he knew the AP was no longer employed at the facility and felt safe residing at the facility.

The text messages retrieved from the client's phone were sent from the cell phone number of the AP which was identified in the AP's personnel file. Texts from the AP to the client included the following messages received over a two day period:
-"Hey it's alright lol not your fault I'm an adult also no worries"
-"your welcome your still my friend and the feeling was awesome"

- “please don’t be mad at me I like you a lot don’t get me wrong we just need to slow down”
-“Alright good we will be friends for sure”
-“Aww thanks I’ll talk to you tomorrow please delete this”
-“Please stop do not tell anyone today I’m nervous to come back”
-“Just please don’t tell anyone I’m serious”
-“Talk to you tomorrow thanks for being so cool”
-“Haha thanks dude please delete the other messages I want to keep my job”
-“I think we should just keep our relationship professional like I’m just aide”

During the facility’s internal investigation, the AP was questioned on the allegations. The AP denied any physical contact with the client. However, during questioning of the incident the AP turned in her keys and resigned from her position.

Review of the AP’s personnel file indicated the AP had received Vulnerable Adult, professional boundaries and bill of rights training and education in the month prior to the incident.

Attempts to contact the AP regarding this investigation were unsuccessful.

A police report was filed in relation to this incident, however was later closed due to lack of response from the AP and the client.

In conclusion, abuse was substantiated.

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: Yes
Family/Responsible Party interviewed: No, client is own responsible party
Alleged Perpetrator interviewed: Attempts to contact the AP were unsuccessful

Action taken by facility:
When the facility became aware of the allegation of abuse, they immediately reported and investigated the incident. In addition, the AP no longer is employed at the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the client'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:
Health Regulation Division – Licensing and Certification
The Office of Ombudsman for Long-Term Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28604	A. BUILDING: _____ B. WING _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HILL SENIOR LIVING	1824 OLD HUDSON ROAD SAINT PAUL, MN 55119

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0 000	Initial Comments *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. On February 18, 2021, a complaint investigation was initiated to investigate complaints HL28604025M, HL28604026C, HL28604027M and HL28604028C. The following correction order is issued related to complaint HL28604027M, tag identification 0325, and complaint HL28604026C, tag identification 0935. At the time of the onsite investigation 80 clients were receiving services under the comprehensive license.	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(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who	0 325		

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0 325	Continued From page 1 receives home care services has these rights: (14) the right to 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 facility failed to ensure one of two clients reviewed (C1) was free from maltreatment. C1 was abused. Findings include: On February 18, 2021, 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.	0 325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report for details.	
0 935 SS=G	144A.4792, Subd. 8 Documentation of Administration of Medication Subd. 8. Documentation of administration of medications. Each medication administered by comprehensive home care provider staff must be documented in the client's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date	0 935		

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0 935	Continued From page 2 and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the client's needs when medication was not administered as prescribed and in compliance with the client's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications were documented and administered as prescribed by the client's physician for one of two clients (C2) reviewed for medication administration. 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) Findings include: C2 was admitted to the facility on 11/29/2019 with diagnoses which included altered mental status, chronic obstructive pulmonary disorder (COPD), anxiety and diabetes mellitus. C2's signed service agreement dated 5/21/2020 included C2 received medication assistance from facility staff	0 935		

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0 935	Continued From page 3 twice daily. Review of C2's physician orders for evening medications included the following: -Oxycodone 2.5 mg tablet at bedtime (HS) as needed (PRN) - Seroquel 50 mg tab every night at HS - Mirtazapine 7.5 mg tablet every night at HS - Metoprolol Tartrate 12.5 mg tablet every night at HS - Metformin 1000 mg every night at HS - Lantus insulin 90 units every night at HS -Duloxetine HCL 30 mg every night at HS -Atorvastatin 40 mg every night at HS C2's September medication administration record (MAR) was reviewed and signed off on 9/25/2020 by ULP-D who documented she administered C2's medications as prescribed by C2's physician. C3's medical record was reviewed which indicated C3 was admitted to the facility on 8/22/2016 with diagnoses which included bipolar disorder, depression, anxiety, diabetes mellitus type II and chronic obstructive pulmonary disorder (COPD). C3's signed service agreement dated 6/18/2020 indicated C3 recieved medication set-up and assistance from facility staff three times per day. C3's physician orders for evening medications included the following: -Simvastatin 80 mg one tablet at HS -Seroquel 400 mg one tablet at HS -Oxybutynin Chloride 5 mg tablet at HS -Lithium Carbonate 300 mg one tablet at HS -Gabapentin 100 mg one tablet at HS -Cymbalta 60 mg one tablet at HS -Cymbalta 30 mg one tablet at HS	0 935		

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0 935	Continued From page 4 C3's September 2020 MAR was also reviewed and indicated ULP-D documented and administered C3's medications as prescribed by C3's physician on 9/25/2020. A facility report provided to the state agency (SA) dated 9/26/2020 indicated a medication error occurred when a staff member/unlicensed personnel (ULP-D) administered the wrong evening medication to C2. When the medication error was discovered staff immediately went to check on C2 and C2 was found on the floor of her room and sent to the hospital. It was later determined that C2 received another client's (C3) medications. The facility completed an internal review of the incident and retrained ULP-D on medication administration. The facility's internal investigation indicated ULP-D documented medication administration to C2 and C3 during the evening medication pass around 7:30 p.m. and ULP-D ended her shift at 8:00 p.m. Around 9:50 p.m. C3 brought her medication cup to another staff member (ULP-E) stating the medications in the cup were not hers. ULP-E then immediately called the nurse (LPN-F) and reported the incident. The medications were reviewed, ULP-D was called regarding her medication pass and it was determined that ULP-D had provided C2's medications to C3 and that C2 had received C3's medications. LPN-F then directed ULP-E to check on C2. ULP-E found C2 on the floor, hard to arouse around 10:00 p.m. and sent C2 to the emergency room via ambulance. Hospital records were reviewed and revealed that C2 was admitted to the emergency room on 9/25/2020 with a diagnosis of altered mental	0 935		

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0 935	Continued From page 5 status, fall and accidental drug overdose. Hospital records revealed C2 had no evidence of head trauma, ability to arouse with loud, verbal and physical stimuli, had an intact gag reflex and clear patent airway and was not in respiratory distress. Labs did not show any acute metabolic abnomality, and displayed anemia although hospital records indicated the patient had a history of anemia. C2's blood pressure was low and C2 was given IV fluids. Hospital records indicated C2 was being monitored for sedation, low blood pressure and monitoring for clearance of drug overdose. Hospital discharge records dated 10/2/2020 indicated C2 was admitted to the hospital due to an unintentional drug overdose and was monitored for clearance of the medications. Upon admission C2 was found to be anemic which was identified as chronic and hospital notes recommend C2 follow up in the weeks following discharge. Additionally, C2's oxygen levels were low and C2 was discharged on oxygen with hospital records indicating this was due to C2's previous diagnosis of COPD. C2 was discharged back to the facility on 10/2/2020. Review of C2's progress notes indicated C2 was re-admitted back to the facility on 10/2/2020 but upon admission C2's o2 saturations were 85% on 2L of oxygen so C2 was again sent to the hospital due to low 02 levels and no signed orders for oxygen. C2's progress note dated 10/14/2020 indicated C2 discharged from the hospital and admitted to another facility.	0 935		

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0 935	Continued From page 6 ULP-D was interviewed regarding the medication error on 2/18/2020 at 12:05 p.m. who confirmed she was the staff member who committed the medication error. ULP-D stated she had never had a medication error prior to this incident and had been trained and supervised in passing medications. ULP-D stated the night the medication error occurred, she had worked a double shift and near the end of her shift she passed the last two medications to C2 and C3. ULP-D stated the medication error was an accident and she was thinking of C2 while reading C3's MAR while punching out medications. ULP-D stated she followed the MAR but gave the wrong medications to the wrong client. ULP-D stated at the time she administered medications to C2 she was unaware of the error. ULP-D stated when she was called by LPN-F regarding C3's report of incorrect medication she realized what had happened and told LPN-F that C2 and C3 were the last medications she had passed on her shift. ULP-D stated she acknowledged her mistake and stated she was remorseful of the incident and confirmed she was removed from passing medication following this incident. ULP-D stated she had to complete full retraining and supervision of medication administration prior to being allowed to pass medications. The Executive Director (ED) was interviewed on 2/18/2020 at 1:00 p.m. who confirmed he participated in the internal investigation of the medication error along with the Director of Nursing (DON) who is no longer employed by the facility. The ED stated that ULP-D committed the medication error, was disciplined and retrained regarding medication administration. The ED stated that medication administration policies were not followed at the time of medication	0 935		

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0 935	Continued From page 7 administration as a medication error occurred. Following the incident, pictures were added to the MARs of all clients to assist in identification of clients and re-education was provided to all staff who pass medications. The facility's Medication Administration Policy dated 7/10/2017 indicated the facility's policy was to safely and correctly administer provide medication administration to clients and documented immediately in the MAR. TIME PERIOD FOR CORRECTION: Seven days	0 935		