DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL29177008M
Compliance #: HL29177009C

Date Concluded: March 27, 2021

Name, Address, and County of Licensee Investigated:
CompassionCare
9000 Golden Valley Road
Golden Valley, MN 55427
Hennepin County

Name, Address, and County of Housing with Services location:
River Bend Apartments
222 North Whitford Street
Fergus Falls, MN 56537
Otter Tail County

Facility Type: Home Care Provider

Investigator's Name: Rhylee Gilb, RN
Special Investigator

Finding: Substantiated, facility and 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 the AP made sexual statements to the client, exposed his genitalia and sent her nude photographs.

Investigative Findings and Conclusion:
Abuse was substantiated. The facility and the alleged perpetrator (AP) were responsible for the maltreatment. The AP emotionally abused the client when he sexually harassed the client over approximately two weeks and exposed his penis to her during the night shift. The AP had a known work history with the facility for being sexually inappropriate towards female staff and a female tenant. The facility failed to remove the AP from having contact with the client upon first receiving notice of the sexual harassment allegation, until the client presented a restraining order.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted law enforcement. The

investigation also included review of the client's record, facility incident reports, the facility investigation, the AP's personnel file, staffing schedules and related policy and procedures. The investigator also interviewed the client and other female client's receiving services.

The client's medical record was reviewed. The client's diagnoses included depression with anxiety and insomnia. The client's service plan included medication administration and reminders for bathing and grooming. The service plan temporarily reflected skin care services for twice a day to apply ointment to a sunburn at 8:00 a.m. and 8:00 p.m. The client's abuse prevention plan indicated the client had the ability to provide information accurately and consistently. She had a vulnerability for inappropriate sexual relationships. Interventions included staff aware of the risk and to discuss good relationships and supervise from unsafe situations.

The AP had two previous employments at facility in a different housing with service location and staff interviews concluded the AP's employment was terminated when it was discovered he was carrying on an inappropriate sexual relationship with a tenant. The AP was the husband of the housing manager at the housing with service location of the investigation and had been rehired approximately two months prior to the report of the allegation. Upon request of the AP's personnel file, the previous employment information was not listed, and the information was not made known until the investigator began interviews. Previous employment records were not made available by the facility including previous disciplinary records and background checks.

One day, the client reported to the registered nurse (RN) the AP was coming into her apartment twice during the night shift over the past two weeks and making inappropriate sexual comments to her, including asking her for a sexual relationship. The client reported she was uncomfortable and began locking her apartment door at night. The client had also contacted law enforcement. The RN reported to the director of nursing (DON), the client had also reported the sexual harassment to law enforcement. The client did not have any services scheduled during the night and the DON stated the AP had no reason to be entering the client's room on the night shift. However, the AP continued to work alone on the night shift during the facility investigation and had keys to access the building at any time.

The facility schedules indicated the AP worked alone on the night shift during the prior month of the allegation a total of 17 days. The client's service record indicated the client had no scheduled services during the night shift. The AP worked alone on the night shift with the client three days after the client first reported the incident.

Four days after the initial report, the client reported further to facility staff the AP also exposed himself to her in her apartment and also shared audio recordings and text messages the AP sent her discussing a sexual relationship with her. The client then presented a restraining order against the AP to the RN. At that time, the RN and DON spoke with the AP, asked him to turn in

his keys to the building and not return to the property. The facility failed to interview other female clients if similar occurrences took place with the AP.

During an interview with the DON, she stated the client did not have services on the night shift and there was no reason the AP should have been going into her room. The DON also stated there was an allegation the AP had engaged in inappropriate conduct at another building during a previous employment, however the relationship was with a tenant of the building who was not a client the facility served.

During an interview, the RN stated the AP did not deny nor confirm the allegation when she spoke to the AP. The RN added, another ULP reported the AP tried contacting a young friend for a sexual relationship and a similar incident happened previously at another facility.

During an interview, the client stated the AP had been coming into her apartment during the night shift, asked for a sexual relationship, made inappropriate sexual comments to her in person, over text message and telephone. The client stated one time, the AP pulled his penis out and told her "he'll be yours some day" and "he" referred to his genitalia. The client stated she was very uncomfortable; she began locking her door more often and was "haunted" by the occurrences.

During an interview, the AP stated he was going into the client's room at night to apply lotion to her sunburns. The AP stated the client agreed to be in a boyfriend and girlfriend relationship with him. He stated one night he worked, he exposed himself to her and she was ok with it and she did not look away. The AP stated he knew he was not supposed to have a relationship with clients per policy, but that they were in a boyfriend girlfriend relationship for a week or two.

The law enforcement report indicated the client reported the AP entering her apartment on several occasions to have conversations with her and exposed his genitals to her. Law enforcement collected a voicemail and text message from the AP to the client outlining a relationship during the time the client reported the interactions occurred. The AP confirmed to law enforcement he did expose himself to the client. The AP was charged with indecent exposure.

In conclusion, abuse was substantiated. The AP treated the client in a manner which was humiliating and harassing. The facility had reason to know or suspect the AP might engage in this type of behavior and multiple staff members knew at least some details of AP’s prior termination. AP had also reached out via social media to a friend of an employee seeking out a sexual relationship. The client’s abuse prevention plan noted that the client was vulnerable to inappropriate sexual relationships. It was reasonable to conclude that, given AP’s history of seeking out sexual relationships with building tenants and client’s vulnerability to inappropriate sexual relationships, the facility had adequate information to not place AP on an unsupervised night shift covering client’s area.

Abuse: Minnesota Statutes section 626.5572, subdivision 2
"Abuse" means:
(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:
(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: Not applicable.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility filed a vulnerable adult report after the initial allegation from the client. The AP was no longer employed by the facility after the second report of additional information. The facility re-trained staff on inappropriate sexual activity and harassment.

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, 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
Ottertail County Attorney
Fergus Falls City Attorney
Fergus Falls City Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H29177	A. BUILDING: _____ B. WING _____	C 09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONCARE	620 MENDELSSOHN AVENUE, SUITE 107 GOLDEN VALLEY, MN 55427

(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 September 29, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL29177009C/#HL29177008M. At the time of the survey, there were 34 clients receiving services under the comprehensive license. The following correction order is issued/orders are issued for #HL29177009C/#HL29177008M, tag identification 0325 and 0880.	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 observations, interviews, and document review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 was abused. Findings include: On October 14, 2020, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that the 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. Based on interview and document review, the licensee failed to provide protection from an unlicensed personnel (ULP)-G from having contact with a client upon first receiving notice of a sexual harassment allegation by a staff member for one of one clients (C1) reviewed, until C1 presented a restraining order four days later. ULP-G had a known work history with the licensee for being sexually inappropriate towards female staff and a female tenant. This practice resulted in a level three violation (a	0 325	No plan of correction is required for tag 0325, please refer to the public maltreatment report for details.	

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0 325	Continued From page 2 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: C1's medical record was reviewed. C1's diagnoses included depression with anxiety and insomnia. C1's service plan dated June 9, 2020, included medication administration at 8:45 a.m., 10:00 a.m. and 8:00 p.m., and reminders for bathing and grooming. In addition, skin care assistance was added at 8:00 a.m. and 8:00 p.m. to apply an ointment to a sunburn. C1's updated service plan dated June 22, 2020, included assistance with medication administration at 8:45 a.m., 10:00 a.m. and 8:00 p.m., and reminders for bathing and grooming. Skin care services were removed. C1's abuse prevention plan dated November 6, 2018, indicated C1 had the ability to provide information accurately and consistently and she did have a vulnerability for inappropriate sexual relationships. Interventions included staff aware of the risk and to discuss good relationships and supervise from unsafe situations. The licensee investigation dated July 3, 2020, indicated registered nurse (RN)-B spoke initially with C1 at 2:59 p.m. C1 reported unlicensed personnel (ULP)-G was coming into her apartment twice during the night shift over the past two weeks and making inappropriate sexual comments to her, including asking her for a	0 325		

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0 325	Continued From page 3 sexual relationship. C1 reported she was uncomfortable and began locking her apartment door at night. C1 had also contacted law enforcement. At 10:38 p.m., RN-B received a call from law enforcement informing her C1 had filed a sexual harassment complaint against ULP-G and law enforcement opened a case to investigate. The licensee schedule dated June 2020, indicated ULP-G was the only staff scheduled and worked the night shift from 11:00 p.m. to 7:00 a.m. on the following dates: June 2, 2020 June 3, 2020 June 4, 2020 June 8, 2020 June 9, 2020 June 12, 2020 June 13, 2020 June 14, 2020 June 16, 2020 (from 10:00 a.m. to 3:00 p.m.) June 17, 2020 June 18, 2020 June 22, 2020 June 23, 2020 June 26, 2020 June 27, 2020 June 28, 2020 June 30, 2020 (from 10:00 a.m. to 3:00 p.m.) The licensee schedule dated July 2020, indicated ULP-G was the only staff scheduled and worked the night shift from 11:00 p.m. to 7:00 a.m. on the following dates: July 1, 2020 July 2, 2020 (from 9:00 p.m. to 7:00 a.m.) July 6, 2020 The licensee failed conduct interviews with other	0 325		

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0 325	Continued From page 4 clients, including female clients to determine if ULP-G had been sexually inappropriate towards anyone else besides C1. The licensee also failed to implement interventions to prevent ULP-G from having contact with C1 during an investigation. The licensee investigation indicated on July 7, 2020, ULP-C reported C1 told her ULP-G exposed himself to her over during the two weeks that she had not previously shared with RN-B. RN-B spoke again to C1 and C1 shared a video recording of ULP-G stating he was interested in a sexual relationship with her and showed a text message regarding ULP-G indicating a relationship with C1. C1 then presented a restraining ordered filed on July 6, 2020 to RN-B. C1's abuse prevention planned indicated it was reviewed on July 7, 2020. During an interview on September 29, 2020 at 3:07 p.m., C1 stated ULP-G had been coming into her apartment during the night shift, asked for a sexual relationship, made inappropriate sexual comments to her in person, over text message and telephone. C1 stated one time, ULP-G pulled his penis out and told her "he'll be yours some day" and "he" referred to his genitalia. C1 stated she was very uncomfortable, she began locking her door more often and was "haunted" by the occurrences. During an interview on September 29, 2020 at 3:48 p.m., director of nursing (DON)-A stated she was on vacation at the time of the allegation on July 3, 2020 and RN-B completed the investigation. DON-A stated C1 did not have services on the night shift and there was no reason ULP-G should have been going into her room. DON-A stated ULP-G ended employment	0 325		

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0 325	Continued From page 5 on July 7, 2020, turned in his keys to the building and asked not to return to the property. DON-A also stated there was an allegation on ULP-G with inappropriate conduct at another building during a previous employment in 2013, however the relationship was with a tenant of the building and not a client the licensee served. During an interview on October 5, 2020 at 3:24 p.m., RN-B stated C1 reported ULP-G exposed himself, sent text messages asking for a sexual relationship and call her over about a week or two. RN-B stated when interviewed ULP-G did not deny nor confirm the allegation. RN-B stated she did not interview other female clients and was not sure if anyone else did. RN-B added, another ULP reported ULP-G tried contacting a young friend for a sexual relationship and a similar incident happened previously at another licensee owned facility. During an interview on October 6, 2020 at 9:14 a.m., ULP-G stated he was going into C1's room at night to apply lotion to her sunburns. ULP-G stated C1 agreed to be in a boyfriend and girlfriend relationship with him. He stated one night he worked, he exposed himself to her and she was ok with it and she did not look away. ULP-G stated he knew he was not supposed to have a relationship with clients per policy. ULP-G stated everyone takes the vulnerable adults side and they were in a boyfriend girlfriend relationship for a week or two. An email with the licensee received October 7, 2021 at 9:23 a.m., indicated ULP-G had previous employements with the licensee from January 29, 2015 through June 19, 2016 and February 10, 2017 through Decemember 31, 2017. The licensee was unable to produce his background	0 325		

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0 325	Continued From page 6 study from those two previous employment periods no any documented disciplinary incidents. The licensee policy titled "Harassment and Offensive Behavior" dated June 2015, indicated sexual harassment is a violation of policy and included unwelcome sexual advances, requests for sexual favors, sexually motivated physical contact, verbal or physical conduct or communication. Such reports of action contrary to the policy will be taken seriously and investigated promptly. TIME PERIOD OF CORRECTION: Seven (7) Days	0 325		