Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL31944008M
Compliance #: HL31944009C

Date Concluded: June 4, 2021

Name, Address, and County of Licensee Investigated:
Birchwood Cottages LLC
1905 Austin Road
Owatonna, MN 55060
Steele County

Name, Address, and County of Housing with Services location:
Birchwood Cottages
1845 Austin Road
Owatonna, MN 55060
Steele County

Facility Type: Home Care Provider

Investigator's Name: Zalei Lewis, RN
Special Investigator

Finding: Substantiated, facility 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 that one client touched another client without consent.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. Client #2 had a documented history of sexually inappropriate behavior, was assessed as at risk of abusing other clients, and there were no specific measures in place to address this risk. Client #2 entered Client #1's room, disrobed, and touched Client #1's intimate area (her clothed groin, inner thigh, or buttocks).

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted family members. Observation of the facility and review of facility documents occurred during this investigation.

Client #1's diagnoses include frontal lobe dementia, hypertension, atrial fibrillation, depression, anxiety, and stress incontinence. She received medication management, assistance with

activities of daily living, laundry services, housekeeping, linen changes, safety checks, and assistance with movement transfers.

Client #2's diagnoses included Alzheimer dementia with paranoia and behavioral complications, hypertension, a history of alcohol abuse, chronic kidney disease, and chronic obstructive pulmonary disease. He received medication management, assistance with activities of daily living, laundry services, housekeeping, safety checks, and behavioral intervention.

Client #2's assessment, performed several months prior, stated "Sexually inappropriate behavior…has been making derogatory remarks to female staff when they are attempting to assist him. Staff are to ignore this type of behavior or tell him this type of talk is not appropriate and walk away if needed, re-approach later if needed." The assessment also states "Client is at risk to abuse other vulnerable adults-specify measures to minimize risk: Our home environment is designed to minimize stress that can cause agitation and our staff has been professionally trained to deal with dementia-influenced behavior. Our staff will attempt to diffuse and redirect aggressive behaviors…. has a history of abusing other vulnerable adults. Staff are to monitor closely, intervene, and report to nursing whenever an incident occurs."

Client #2's treatment plan does not specify measures taken to minimize the risk of this client abusing others. No patient specific interventions or procedures are contained in the treatment plan to prevent or intervene in client sexual inappropriateness toward other clients, although that risk was documented in the assessment described above. No patient specific measures, or observations at specific intervals, were in place in ensure Client #2, who was known to wander, would not enter other clients' rooms.

During the early hours of late March 2021, one staff member entered Client #1's room and encountered Client #2, who did not reside in that room, and was naked, with his hand placed on top of Client #1's incontinence product, which covered her groin, inner thigh, and buttocks. The staff member stated that he then called out to the other staff member for assistance. Client #2 was escorted back to his room and clothed.

During the investigation, staff members were interviewed. A staff member stated that while doing rounds "we were checking on [Client #2] …we couldn't find him, so we started checking rooms. He was in his neighbor's room in a state of undress…he was touching her Depends." Client #2 was not observed or heard going into Client #1's room. Staff members did not know how long the client had been in the other client room, or what occurred in the room. Staff interviewed stated that Client #1 did not recall another client in her room.

Another staff member stated that Client #2 "has sexual behaviors and stuff. He will go in the corner and, like, just pull down his pants. In fact, there have been like moments where he'll take out his penis, you know, and we have to tell him no."

In conclusion, neglect was substantiated. The facility failed to implement adequate measures in response to Client #2's documented risk of abusing other vulnerable adults, and this contributed to an incident where Client #2 engaged in nonconsensual sexual contact with Client #1.

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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: One client was interviewed, the other client declined the interview.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility called the family members of the clients involved, placed a cloth barrier over part of one client's door, and re-educated staff.

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.

cc:

The Office of Ombudsman for Long-Term Care
Owatonna City Attorney
Owatonna Police Department
Steele County Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H31944	A. BUILDING: ______ B. WING ______	C 05/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD COTTAGES	1905 AUSTIN ROAD OWATONNA, MN 55060

(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 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 investigation. 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 May 10,2021 the Minnesota Department of Health initiated an investigation of complaint #HL31944009C/#HL31944008M. At the time of the investigation, there were #23 clients receiving services under the comprehensive license. The following correction orders are issued. The following correction orders are issued for #HL31944009C/#HL3194408M, tag identification 0265 and 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).	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE

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0 265	Continued From page 1	0 265		
0 265 SS=G	144A.44, Subd. 1(a)(2) Up-To-Date Plan/Accepted Standards Practice Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (2) receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide care according to accepted health care standards, when the facility failed to implement interventions to protect clients from nonconsensual sexual contact from another client with a history of sexual behaviors. As a result, the other clinentered C1's room and touched C1's groin area. 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 a 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 record was reviewed; diagnoses included	0 265		

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0 265	Continued From page 2 Frontal Lobe Dementia, Hypertension, Atrial Fibrillation, Stress Incontinence, Diabetes Mellitus Type II, Depression, and Anxiety. C2's record was reviewed; diagnoses included Alzheimer dementia, Advanced dementia with paranoid and behavioral complications, Hypertension, Chronic Kidney Disease, History of multiple falls, and History of Alcohol Abuse. C2 was accepted to facility from a geropsychiatric hospital unit. C2 had a history of disorientation, wandering, disturbed sleep including disrupt others during the night and not responding to redirection, agitation, combativeness, sexually inappropriate behavior, physically abusive/disruptive behavior, and verbally abusive behavior. C2's assessment stated "Sexually inappropriate behavior" and also states "Client is at risk to abuse other vulnerable adults-specify measures to minimize risk: Our home environment is designed to minimize stress that can cause agitation and our staff has been professionally trained to deal with dementia-influenced behavior. Our staff will attempt to diffuse and redirect aggressive behaviors .... has a history of abusing other vulnerable adults. Staff are to monitor closely, intervene, and report to nursing whenever an incident occurs." No patient specific interventions or procedures are contained in the treatment plan to prevent or intervene in client sexual inappropriateness toward other clients Facility charting March 14, 2021, under the category of AM-Behavioral-Sexually Inappropriate states, "client would not leave female residents alone." On May 10, 2021, the facility internal investigation was reviewed. Internal investigation included	0 265		

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0 265	Continued From page 3 interview of staff and video review. No staff directly involved in discovery of incident were included in the internal investigation documents provided. Facility review of internal video footage revealed C-2 entered C-1's room. C1's progress note dated March 31, 2021, states, "RA reported knowledge of sexual conduct by a peer during the night shift. RA reported that peer was found standing naked in room touching resident's vagina. VA reported to MAARC site. RA was interviewed by this writer. Skin assessment completed by RN found no skin issues or signs of trauma. RN interviewed resident who had no recollection of incident. Resident was in good spirits. Behavior and mood monitoring will be completed for the next couple of weeks." C1's progress note dated April 1, 2021, states, "Resident noted to be alert and fed self breakfast. Now resident has eyes closed and continuously saying 'help me mother and father, help me father bring me my snack. Minister help me,' resident repeating in mono tone voice at this time and is fairly quiet." On March 13, 2021, ULP-C was interviewed and stated "(C2) is naked at (C1"s) bed with his hand on her brief." On March 14, 2021, ULP-B was interviewed and stated "we were checking on (C2) ...we couldn't find him, so we started checking rooms. He was in his neighbor's room (C1) in a state of undress ...he was touching her Depends." The Birchwood Cottages policies and procedures were reviewed. "Birchwood Cottages Policies and Procedures Subject: Monitoring of Residents and their Services states: Policy: The RN will monitor residents' needs and services on an	0 265		

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0 265	Continued From page 4 ongoing basis to determine if the services are appropriate to the resident's needs or if changes in the service plan are needed. The RN will also identify any problems or resident concerns; evaluate the effectiveness of the services, medications and treatments; and identify any changes in condition or new symptoms. Procedure ...Identify any new vulnerability that the resident may have or any new risk that the resident may pose to other vulnerable adults and identify interventions to address these issues. Any changes in the interventions will be documented in the resident record and will be communicated to staff providing services to the resident." ongoing basis to determine if the services are appropriate to the resident's needs or if changes in the service plan are needed. The RN will also identify any problems or resident concerns; evaluate the effectiveness of the services, medications and treatments; and identify any changes in condition or new symptoms. Procedure ...Identify any new vulnerability that the resident may have or any new risk that the resident may pose to other vulnerable adults and identify interventions to address these issues. Any changes in the interventions will be documented in the resident record and will be communicated to staff providing services to the resident." TIME PERIOD FOR CORRECTION: Seven days	0 265		
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 in an assisted living facility licensed under chapter 144G has these rights:	0 325		

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0 325	Continued From page 5 (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 that one of two clients reviewed was free from maltreatment when another client trespassed into C-1's room and C-1 was touched by another client, over brief region, while lying in her bed. Findings include: On June 4, 2021 the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with an incident 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 (report sent separately) for details of tag 0325.	