Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL33356031M
Compliance #: HL33356032C

Date Concluded: March 25, 2021

Name, Address, and County of Licensee Investigated:
Ebenezer Management Services
7505 Metro Boulevard #100
Edina, MN 55439
Hennepin County

Name, Address, and County of Housing with Services location:
The Pillars of Mankato
3125 Prairie Rose Drive
Mankato, MN 56001
Blue Earth County

Facility Type: Home Care Provider

Investigator's Name: Christine Bluhm, RN
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:
It is alleged: The alleged perpetrator (AP) sexually assaulted the client in her apartment.

Investigative Findings and Conclusion:
Abuse was substantiated. The AP, a staff person, was responsible for the maltreatment. The AP's sexual assault of the client was recorded by video surveillance. The AP also admitted to police he sexually assaulted the client.

The investigation included interviews with facility staff. The investigation included a review of facility policies and procedures. The AP's personnel file was reviewed for appropriate background checks and training. The client's medical record was also reviewed. Law enforcement was also contacted during this investigation.

The client had a history of dementia and heart disease. The client's service plan indicated she required assistance from staff for medication management, standby bathing assistance, incontinence care, meals, and housekeeping. The client could walk independently with a four-

wheeled walker. The client was alert and oriented but had difficulty with her memory. She wore a call pendant that she could use to request staff assistance. The client had video monitoring in her apartment.

One evening, an alert was sent to the client's family member's phone with live stream video from inside the client's apartment. The video showed a male staff person, identified as the AP, sexually assaulting the client. The family member called 911, and police were dispatched to the facility. The AP was arrested as he was leaving the facility.

During interview, an unlicensed staff person that worked the evening of the assault stated the AP did not attend the end of shift report around the same time the assault occurred.

During interview, the director of health services stated the AP was a scheduled resident assistant for the client, and there were no other males assigned to her care at that time.

During interview, the executive director stated the AP had the required background study completed, as well as verified credential checks prior to beginning employment at the facility.

The client was interviewed and stated that she could not remember details of the assault.

Review of the county attorney criminal complaint indicated the AP was charged with multiple felony counts of criminal sexual conduct. The criminal investigation was still ongoing at the time of this report.

In conclusion, sexual abuse was substantiated. The AP was responsible for the abuse.

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:
(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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No. The AP could not be reached for interview.

Action taken by facility:
The facility conducted an internal investigation of the incident with clients and staff interviewed. The AP is no longer working at the facility.

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
Blue Earth County Attorney
Mankato City Attorney
Mankato Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H33356	A. BUILDING: _____ B. WING _____	C 03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER MANAGEMENT SERVICES INC	2722 PARK AVENUE MINNEAPOLIS, MN 55407

(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 an 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 March 17, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL33356032C/#HL33356031M. At the time of the investigation, there were #51 clients receiving services under the comprehensive license. The following correction order is issued for #HL33356032C/#HL33356031M , 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 (C1) reviewed was free from maltreatment. C1 was sexually abused. Findings include: On March 21, 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) is required. Please refer to the public maltreatment report for details.	