Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL36449001M
Compliance #: HL3644002C

Date Concluded: April 13, 2022

Name, Address, and County of Licensee Investigated:
Partners In Care Inc.
2817 Hampshire Ave
Crystal, MN 55427
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Carrie Euerle MSN, 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): Neglect of supervision occurred when a resident (Resident #1) was sexually assaulted by another resident (Resident #2) of the facility.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to assess, monitor and implement interventions to ensure resident safety. Despite knowledge of Resident #1's vulnerability to sexual abuse, the facility did not assess the resident for susceptibility for abuse and did not initiate safety interventions. Instead, Resident #1 was housed on the same floor as Resident #2, who had sexually assaulted someone else in the past, without adequate precautions or supervision in place. In addition, the facility was left unattended by staff for an unknown period, during which the incident occurred.

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

Observations were not made during the onsite visit as the residents no longer resided at the facility.

Resident #1 was admitted to the facility with diagnoses of autism with cognitive and language deficits and depression with psychotic episodes. Resident #1 was independent with mobility and transfers and required assistance of staff for medication management and personal cares including dressing, grooming, and bathing. A facility vulnerability assessment indicated the resident was not at risk for abuse or neglect despite previous assessments, provided to the facility upon admission, which indicated the resident was highly vulnerable, unlikely to report abuse or neglect, put herself in dangerous situations, was unable to protect herself or make decisions regarding safety, and was inappropriate with boundaries including discussions about sex and making sexual jokes in inappropriate situations. No safety interventions were put in place upon the resident's admission to the facility.

Resident #2 was admitted to the facility with diagnoses which included post-traumatic stress disorder (PTSD), bipolar disorder and manic depression. Resident #2 was independent with all activities of daily living, however he required staff assistance with reminders and cues for grooming, dressing, and bathing and medication management. A vulnerability assessment completed by the facility upon Resident #2's admission to the facility indicated the resident had a history of sexual abuse and directed staff to check on the resident every two hours and not allow the resident into other residents' rooms.

Review of facility documents, medical records, police records and staff interviews indicated the staff member working the night the incident occurred had stepped outside of the facility to smoke, leaving the facility unattended. The staff person heard a noise from inside the facility. Upon re-entering the facility, the staff member saw Resident #1's door open. Resident #1 was upset and saying Resident #2 had been "touching her." The staff member immediately tried to ensure Resident #1's safety and called another employee to come to the facility for assistance. When the other staff member arrived, they called the director and the police regarding the incident. In addition, Resident #1 had called a family member regarding the incident and the family member arrived at the facility. During this time, staff attempted to locate Resident #2, and determined he had left the facility.

Police arrived at the facility and interviewed Resident #1, who provided statements which indicated Resident #2 had entered Resident #1's room, showed her pornographic material, performed oral sex, forced the resident to perform oral sex, digitally penetrated and attempted to have sexual intercourse with the resident.

Resident #1 was sent to the hospital for a sexual assault exam to be completed following the statement provided to police. The report from the sexual assault exam noted bleeding from Resident#1's vagina during the speculum exam.

Police later found Resident #2 walking along the road a short distance from the facility. Police interviewed Resident #2 regarding the allegation. Resident #2 was then arrested. Resident #2 was later charged with third degree criminal sexual conduct and did not return to the facility.

The guardian of Resident #1 was interviewed and indicated she was aware of the incident and following the incident had learned Resident #2 had a prior history of sexual assault. The guardian indicated that s/he would not have placed Resident #1 in this facility with Resident #2 had s/he known of Resident #2's history.

Resident #2 was not available for interview as he remained in police custody.

In conclusion, neglect of supervision 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.

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: No
Family/Responsible Party interviewed: Yes, guardian interviewed. Attempts to contact family were unsuccessful.
Alleged Perpetrator interviewed: N/A

Action taken by facility:
When the facility learned of the incident, they immediately contacted the police and Resident #2 did not return to the facility.

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:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Crystal City Attorney
Crystal Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36449	A. BUILDING: _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARTNERS IN CARE INC	2817 HAMPSHIRE AVENUE NORTH CRYSTAL, 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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint 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: #HL36449002C/HL36449001M On March 3, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were four clients receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL36449002C/HL36449001M, tag identification 0630 and 2360.	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 Assisted Living Facilities. 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 evaluators ' 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 144G.31 SUBDIVISION 1-3.	
0 630 SS=I	144G.42 Subd. 6 Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement an individualized abuse prevention plan (IAPP) which included an individualized review or assessment of the person's susceptibility of abuse to others or by another individual, failed to include specific measures to reduce risk of abuse and lacked inclusion of known vulnerabilities for 2 of 2 (R1, R2) residents with records reviewed. R1 had known vulnerabilities which increased her susceptibility to sexual abuse, and the licensee failed to document this on her IAPP and failed to develop interventions to address it. R2 had a documented history of sexual assault, and the licensee failed to develop and implement adequate interventions to address this. The licensee placed R1 and R2 in adjoining rooms, and R2 had nonconsensual sexual contact with R1. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to	0 630		

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0 630	Continued From page 2 serious injury, impairment, or death and and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: R1 was admitted to the facility on May 24, 2021, with diagnoses which included autism with cognitive and language deficits and depression with psychotic episodes. R1 was admitted to the facility with a February 12, 2020, assessment report completed by the county which identifed the following vulnerabilities: highly vulnerable, unlikely to report abuse or neglect, puts self in dangerous situations, unable to protect self or make decisions regarding safety, and was inappropriate with boundaries including discussions about sex, and making sexual jokes, in inappropriate situations. Upon R1's admission the facility, the facility nurse completed an Individual Abuse Prevention Assessment Plan (IAPP), dated May 24, 2021, which indicated R1 was not susceptible for sexual, physical or self abuse. The IAPP identified each category individually which included the headlines of sexual abuse, physical abuse and self abuse; all three areas were checked "No" and no interventions were developed under these categories. The IAPP included instructions on completing the assessment located at the top of the assessment which indicated when the first statement in an assesment category has been marked, no other categories should be marked, and a plan of	0 630		

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0 630	Continued From page 3 action is not required. The instructions further included to ensure accuracy in completing the assessment and plan, information contained in any applicable incident reports, injury reports, vulnerable adult reports and other assessments should be considered. R2 was admitted to the facility on January 13, 2021 with diagnosis which included post-traumatic stress disorder (PTSD), bipolar disorder and manic depression. R2 was admitted to the facility with a previous completed assessment by the county, dated August 26, 2020, which indicated R2 had a history of assualt, drug related crimes, financial crimes and sexual crimes. The assessment further indicated R2 reported ,he was a Registered Sex Offender. R2's facility IAPP, dated January 13, 2021, identified under the behavior category that R2 had a history of sexual abuse and directed staff to redirect and reassure R2, monitor R2 daily, complete every two hour safety checks and not allow R2 into any other residents' rooms. The IAPP indicated R2 was not at risk for sexual, physical or self abuse, however did not indicate whether R2 was at risk for abusing other vulnerable adults. In addition, the IAPP included a section which asked if the facility was aware of this resident committing a violent crime or and act of physical aggression towards others. The box was checked "Yes". Below the above category the IAPP indicated for the facility to identfy specific measures to be taken to minimize the risk the resident might pose to visitors or persons outside the facility if unsupervised. Following this	0 630		

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0 630	Continued From page 4 question it stated "Individual Abuse." No further interventions or measures to minimize risk to others were identified. A second facility Vulnerability Assessment/Abuse Prevention Plan assessment completed for R2, dated January 13, 2021, indicated R2 was not at risk for abusing another individual, including vulnerable adults. The end of the assessment concluded with the facility identifying by checking boxes that R2 does not appear to have any areas of vulnerability requiring interventions at this time and checked another box indicated R2 has some identified areas of potential vulnerability but there are no signs of abuse or neglect. The area which asked if R2 may pose a risk to other vulnerable adults was left blank. A facility incident report, dated November 1, 2021, indicated on October 31, 2021, R1 reported to facility staff that she was sexually assualted by R2. Facility staff called the police, reported the incident and sent R1 to the hospital for a sexual assualt examination. R2 eloped from the facility after the incident occurred and was later located by police. A police report dated November 1, 2021, indicated R1 and R2 were interviewed by police. R1 provided a statment to police which included R2 entered her room, showed her pornographic material, performed oral sex, forced the resident to perform oral sex, digitally penetrated and attempted to have sexual intercourse with the resident. R2 was arrested, taken into custody and charged with third degree criminal sexual conduct. During an interview on March 3, 2021, at 11:45 a.m., executive director (ED)-A indicated at the	0 630		

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0 630	Continued From page 5 time the incident occurred there were three residents of the facility and the facility had two empty rooms on the upper level of the facility near the staff office and common areas. R1 and R2 resided in the basement of the facility; only two resident rooms were located in the basement. ED-A stated R1's room was in the basement due to the steps and R1 not liking going up the steps due to her weight. ED-A indicated he had wanted R1 to be in an all female house for her comfort and safety but this was not available at the time. ED-A indicated he was aware of prior convictions that R2 had but had not been aware of any need for concern other than that identified in the careplan or IAPP. The ED provided documentation which indicated every two hour checks were completed on R2, however the incident occured between the hours of the checks completed by staff. ED-A confirmed R1 and R2's county assessments were provided to the facility prior to their admission to the facility and the Registered Nurse (RN) was responsible for completing any further assessments at the facility using that information. During an interview on March 25, 2022 at 10:30 a.m., RN-D confirmed she completed R1's vulnerability assessment, however she did not complete R2's assessment as that was completed by the nurse prior to her employment. RN-D confirmed the county assessments from R1 and R2 would have been reviewed prior to admission at the facility to understand the resident and also upon admission to the facility. RN-D indicated much of the information regarding a resident is located within the county assessment. RN-D stated she reviewed R1's county assessment prior to her admission at the facility and completed the facility vulnerability assessment. RN-D confirmed that the	0 630		

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0 630	Continued From page 6 vulnerabilities identified in the county assessment should have been included on the facility assessment. RN-D could not explain why the facility assessment did not include the vulnerabilities identified on the county assessment however indicated she had learned alot from this incident and going forward would ensure that vulnerabilities were clearly identified and appropriate interventions would be included on the facility assessments. A facility Vulnerable Adult policy dated April 13, 2021, indicated the facility is required to individually assess clients to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse to that client. The policy further outlined facility procedure which included assessment of vulnerability status of each client is complete upon admission and usceptibility to abuse includes self abuse and neglect and risk of abuse by other individuals, including other vulnerable adults or minors, as well as physical, verbal, sexual, and self abuse as well as financial exploitaion. Upon completion of assessment the facility will develop an individual abuse prevention plan for each resident to include statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults/minors. The plan will be implemented immediately and evaluated at each supervisory visit or more frequently, if necessary and documentation will include results of the implementation. Time period for correction: Seven (7) days	0 630		

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02360	Continued From page 7	02360		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure one of two residents reviewed (R1) was free from maltreatment. R1was neglected. Findings include: On April 13, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility 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.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	