Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H5520094M
Compliance #: H5520092C

Date Concluded: January 10, 2022

Name, Address, and County of Licensee Investigated:
Redeemer Residence
625 West 31st Street
Minneapolis, MN 55408
Hennepin County

Facility Type: Nursing Home

Evaluator's Name: Jill Hagen, 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(s):
It is alleged: The alleged perpetrator (AP) sexually abused Resident #1 and Resident #2 when the (AP) fondled their breasts; made Resident #1 hold his penis in her hands; and kissed Resident #2 on the cheek. Both Resident #1 and Resident #2 verbalized fear of the AP.

Investigative Findings and Conclusion:
Sexual abuse was substantiated. The alleged perpetrator (AP) was responsible for the maltreatment. Resident #1 and Resident #2 provided consistent recollections of the sexual abuse, both Resident #1 and Resident #2 were cognitively capable of remembering the sexual incident(s), and the AP's job history included past allegations of fondling female residents.

The investigation included interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of resident's medical records, the facility investigation, the prior federal survey interviews and documentation, and the AP's personnel file. The investigator contacted law enforcement.

Resident #1's medical record indicated the resident had diagnoses including cerebral vascular accident (stroke) with residual weakness. Resident #1 was able to make her needs known to staff and required staff assistance to complete all activities of daily living including toileting, transfers, and repositioning in bed. Resident #1 required stand by assistance from staff to ambulate with a wheel walker, and mostly used the wheelchair for mobility. Resident #1 was at risk for abuse by others and able to report abuse.

Resident #2's medical record indicated the resident had diagnoses including a cerebral vascular accident with residual left side weakness and admitted to the facility for short term rehabilitation. Resident #2 was capable of making her needs known and required staff assistance to complete activities of daily living including transfers and toileting and repositioning in bed. Resident #2 used a wheelchair for all mobility. Resident #2 had a history of abuse or neglect, was at risk for abuse, and was able to report abuse.

A facility incident report indicated Resident #1's family member (FM) reported to the facility the AP comes into Resident #1's room at night and fondles the residents' breasts. The FM provided a physical description of the AP.

A facility incident report indicated Resident #2 reported to the facility the AP fondled both her breasts and kissed her cheek. Resident #2 identified the AP by a series of photos of multiple staff.

The law enforcement investigation indicated Resident #1 told a FM the AP fondled her breasts over her clothes and forced Resident #1 to touch the AP's genital area. Resident #1 preferred not to speak directly to the police for fear of reprisal from the AP. The report indicated the police interviewed Resident #1's FM. Initially, Resident #1 told the FM the AP was touching and squeezing her breasts. The AP placed Resident #1's hand on his genitals. Resident #1 stated the AP worked during the night and she was afraid during the night when the AP was working. Resident #1 was embarrassed by the sexual abuse, and she hesitated to report the abuse to facility staff.

The police report indicated during the facility investigation the staff conducted additional resident interviews. At that time, Resident #2 stated the AP fondled her breasts and kissed her cheek. Resident #2 was fearful of the AP and declined an interview with the police for fear of reprisal by the AP.

The police report indicated the AP denied the allegation of sexual abuse of Resident #1 and Resident #2 when interviewed by the police.

Resident #1 was interviewed by a department of health surveyor and stated the AP worked during the night and assisted her with toileting. The AP touched Resident #1's breast and stood next to Resident #1's bed placing his penis in Resident #1's hand. Resident #1 stated the AP

placed his penis in her hand and made her hold it occurred approximately three to four different times. Resident #1 stated she felt terrible and abused and wondered what she did to make the AP abuse her.

Resident #2 was interviewed by a department of health surveyor and stated the AP began grabbing Resident #2's breasts a few weeks earlier during the night shift. Resident #2 stated the AP grabbed her breasts about four to five different occasions. On one occasion, the AP entered Resident #2's room, rubbed her head, and kissed Resident #2 on the cheek. Resident #2 was afraid to use her call light when she needed assistance during the night because she was afraid the AP would respond. Resident #2 said she had nightmares after the abuse by the AP.

When interviewed the director of nursing (DON) stated when the facility became aware of the allegation of sexual abuse by the AP, she and the licensed social worker interviewed Resident #1. Resident #1 stated the AP groped her breasts, was inappropriate with her, and she expressed fear of the AP. While interviewing additional residents for the investigation, Resident #2 stated the AP fondled her breasts and kissed her on the cheek. DON stated she felt both Resident #1 and Resident #2 provided credible information. Because Resident #1 was embarrassed, she later reported to the FM the AP made her hold his penis in his hand. The AP denied the allegation of sexual abuse of Resident #1 and Resident #2.

During an interview, the facility licensed social worker (LSW) stated Resident #1's FM approached her to report an allegation of sexual abuse against the AP. LSW spoke with Resident #1 and the FM who reported the AP inappropriately touched Resident #1's breasts and grabbed Resident #1's hand placing it on the AP's penis. During additional resident interviews, Resident #2 stated the AP fondled and squeezed her breasts. Resident #1 and Resident #2 identified the AP by staff photos.

During interview Resident #1's FM stated Resident #1 stated the AP fondled and squeezed her breasts. During the night shift, when in the bathroom with the door closed, the AP made Resident #1 touch his private area. Resident #1 said she was terrified and fearful of retaliation by the AP.

When interviewed the AP denied the allegation of sexual abuse of Resident #1 and Resident #2. The AP said Resident #1 did not share with him she had issues or concerns with the AP. The AP also denied awareness of and the allegation of sexual abuse with Resident #2. The AP stated he had no prior complaints from the facility or from residents regarding the care he provided.

Review of a federal data base that tracks previous allegations of maltreatment of vulnerable adults indicated the AP had worked for the facility for approximately five years. The AP had three additional previous allegations of touching/fondling, and sexual abuse towards other residents at the facility.

The police investigation into the allegation remained open.

In conclusion, abuse was substantiated. Resident #1 and Resident #2 were cognitively capable and provided consistent recollections of the AP's sexual abuse. The AP had a history of allegations of sexual 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:
(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.
(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. Resident #1 and Resident #2 declined an interview about the alleged sexual abuse.
Family/Responsible Party interviewed: Yes. Resident #1's family member. Resident #2 was her own responsible person.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility provided staff education on their vulnerable adult policy and procedure. Management interviewed all residents regarding vulnerable adult issues. The facility completed an audit of staff knowledge of the facility's vulnerable adult policy. At resident quarterly care conferences staff included specific questions about abuse. The AP was no longer employed by 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. 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
Minneapolis City Attorney
Minneapolis Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00160	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	**625 WEST 31ST STREET MINNEAPOLIS, MN 55408**

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H5520094M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders	2 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the	

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2 000	Continued From page 1 are issued for #H5520094M, tag identification 1850. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000	far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" State Team ACO Initial Comments portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the evaluators findings are the Suggested Method of Correction and 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/RULES	
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from	21850		1/19/22

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21850	Continued From page 2 non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure twp of two residents reviewed (R1 and R2) was free from maltreatment. R1 and R2 were abused. Findings include: On January 10, 2022, 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.	21850	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	