Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HG0101561M
Compliance #: HG0102043C

Date Concluded: December 22, 2022

Name, Address, and County of Licensee Investigated:

Harry Meyering Center
109 Homestead Road
Mankato, MN 56001
Blue Earth County

Facility Type: Intermediate Care Facility (ICF)

Evaluator's Name: Barbara Axness, RN
Special Investigator
Jill Hagen, RN
Special Investigator

Finding: Inconclusive

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.

Initial Investigation Allegation(s):
The alleged perpetrator (AP), an unlicensed staff member, sexually abused a client when the AP inserted his fingers into the client's vagina four times and placed his penis on the client's face.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Although the client non-verbally communicated to staff that the AP inserted his fingers into her vagina and placed his penis on her face, the AP denied the allegation. The AP stated he provided the client peri-care and used his fingers to clean the client's vagina of bowel movement. A sexual assault exam completed at a local hospital, indicated there was no evidence of injury to the client. Due to difficulty with the client's sexual assault exam, no physical evidence could be collected.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the client's guardian. The investigation included review of emergency room records, the client's medical records including assessments and service plan, a police investigation, and the facility's internal investigation.

The client resided in an intermediate care facility. The client's diagnoses included aphasia (a comprehension/communication disorder) and cerebral palsy. The client's service plan indicated the client required assistance with transfers, activities of daily living, and toileting. The client's assessment indicated the client was nonverbal and communicated with the use of a Dynavox (a device used to communicate by using eye movements and gazes). At the time of the allegation, the client's Dynavox was in for repair and the client communicated to staff using head and hand gestures.

Emergency room records indicated the client was evaluated by a sexual assault nurse examiner (SANE) after an allegation that a male staff member digitally penetrated her vagina. The client's hospital records indicated an external exam was performed and no obvious signs of injury or bleeding were present. The records indicated the client denied penetration and swabs were not collected.

The police report indicated a forensic interview was conducted with the client and the client stated the alleged perpetrator (AP) touched her on the nipples and private areas/pubic hair and that his hand went inside of her private area. The client further alleged the AP put her hand on his bare skin penis. The client stated this happened only one time.

The police report indicated the AP was interviewed and denied sexually assaulting the client. The AP told police he did touch her "private area" but did so because he was cleaning up a bowel movement that had smeared into her vaginal area. The report indicated the AP did not put the client's hand on his crotch.

The facility's internal investigation indicated they became aware of the allegation when unlicensed personnel (ULP) felt uncomfortable with the way the AP provided cares to the client and reported it to a supervisor. The ULP went back to the client's room and asked the client if the AP had done inappropriate things. The client "looked up and moved her hands down," which prompted further questioning from the ULP. The ULP indicated s/he asked yes or no

questions and the client indicated she was assaulted by the AP and he put his fingers inside of her vagina. Two other staff members interviewed the client and when the client again indicated the AP touched her in a way that made her uncomfortable, police were contacted. The police directed staff to not interview the AP.

A federal surveyor interviewed the AP who stated he was suspended but was not sure why as the facility would not tell him. The AP informed the federal surveyor he provided perineal cares after the client had a bowel movement and did not notice any concerns from the client at that time.

Numerous attempts were made to contact management at the facility without a response.

Numerous attempts made to contact the AP through telephone calls, emails, and a subpoena were also unsuccessful.

In an interview, the client's guardian stated the client had not made previous allegations of sexual abuse against facility staff. The guardian stated the client did have, what she considered, some reactive attachment responses and would sometimes have behaviors if she didn't want to participate in something.

In an interview, the client's mother stated the client did not have a history of allegations of sexual abuse and indicated the facility staff responded immediately due to feeling the allegation was credible.

In conclusion, it was inconclusive whether abuse occurred.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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: Unable
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Attempts to interview were unsuccessful

Action taken by facility:
The facility immediately suspended the AP and conducted an internal investigation. The AP’s employment was later terminated.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01008	A. BUILDING: _____ B. WING _____	C 10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY MEYERING CTR INC	109 HOMESTEAD ROAD MANKATO, MN 56001

(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
5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, 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 or MN Statute indicated below. When a rule or statute 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. The Minnesota Department of Health investigated an allegation of maltreatment, complaint #HG0101561M in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	5 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Supervised Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule	

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5 000	Continued From page 1	5 000	out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" 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." 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.	