



Office of Health Facility Complaints Investigative Report  
PUBLIC

<b>Facility Name:</b> Delphi	<b>Report Number:</b> HG211003	<b>Date of Visit:</b> October 13, 2017
<b>Facility Address:</b> 1411 East Shakopee Avenue	<b>Time of Visit:</b> 9:35 a.m. to 3:30 p.m.	<b>Date Concluded:</b> January 22, 2018
<b>Facility City:</b> Shakopee	<b>Investigator's Name and Title:</b> Jane Aandal, RN, Special Investigator	
<b>State:</b> Minnesota	<b>ZIP:</b> 55379	<b>County:</b> Scott

ICF/IID

**Allegation(s):**

It is alleged that neglect of supervision occurred when Clients' #1 and #2 were inappropriately touched by another Client #3.

- Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
- State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- State Statutes Chapters 144 and 144A

**Conclusion:**

Based on a preponderance of evidence, neglect occurred when the facility failed to provide adequate supervision of three clients resulting in Client #3 inappropriately touching Client #1 and Client #2. Client #1 and Client #2 were diagnosed with moderate intellectual disability. Client #3 was diagnosed with moderate intellectual disability and Down syndrome.

Client #1's documentation indicated Client #1 would likely seek or cooperate in an abusive situation due to sexual interest and desire. Client #1's guardian felt it would be inappropriate for Client #1 to have a sexual relationship with his/her housemate. Client #1 was interviewed and stated Client #3 touched his/her chest above the breasts. Client #1 stated s/he was nervous and hollered for staff. Client #1 was unable to state if the touching occurred over or under pajamas.

Client #2's documentation indicated Client #2 had expressed affection towards others in ways that show a lack of boundaries. Client #2 was interviewed and stated s/he remembered Client #3 came into the room and touched him/her. Client #2 told Client #3 no. Client #2 was unable to state if the touching occurred over or under pajamas.

Client #3 had a known history of inappropriately touching Client #1 and Client #2. Client #3 was interviewed and stated s/he entered the bedroom of Client #1 and Client #2 and the room was dark. Client #3 denied touching Client #1 and Client #2.

Client #1 and Client #2 shared a bedroom on the same level of the house as Client #3. During the evening or night, after Client #1 and Client #2 were in bed, Client #3 entered their bedroom. Client #3 then touched Client #1's chest area and back. Client #3 also touched Client #2's pelvic area. Client #2 told Client #3 to leave the room and s/he did. Client #1 reported the incident to staff in the morning.

Staff indicated during interview that they should know the location of Client #3 when s/he was in the house, even though there was not a written supervision plan. Staff interviews indicated they trusted the reporting of the incident given by Client #1 and Client #2. Staff stated they were instructed to know the location of Client #3 when s/he was in the house.

The facility called Client #3's family when Client #1 reported the incident. Family took Client #3 home that day for the safety of all clients and Client #3 was discharged to another facility.

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Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

- Abuse
- Neglect
- Financial Exploitation
- Substantiated
- Not Substantiated
- Inconclusive based on the following information:

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**Mitigating Factors:**

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the  Individual(s) and/or  Facility is responsible for the

Abuse  Neglect  Financial Exploitation. This determination was based on the following:

The facility failed to have a system to provide adequate supervision of Client #3, when s/he had the ability to enter Client #1 and Client #2's bedroom. The facility failed to fully inform staff of Client #3's previous sexual behavior towards Client #2 and address those behaviors in his/her vulnerable adult plan.

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.

**Compliance:**

Federal Regulations for ICF/IID (42 CFR, Part 483, subpart I) – Compliance Met

The facility was found to be in compliance with Federal Regulations for ICF/IID (42 CFR, Part 483, subpart I).

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No deficiencies were issued.

State Licensing Rules for Supervised Living Facility (MN Rules Chapter 4665) – Compliance Met  
The facility was found to be in compliance with State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665). No state licensing orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met  
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued:  Yes  No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met  
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued:  Yes  No

(State licensing orders will be available on the MDH website.)

**Compliance Notes:**

**Definitions:**

**Minnesota Statutes, section 626.5572, subdivision 17 - Neglect**

"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.

Facility Name: Delphi

Report Number: HG211003

**Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated**

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

**The Investigation included the following:**

**Document Review: The following records were reviewed during the investigation:**

- Medical Records
- Other, specify:

**Other pertinent medical records:**

**Additional facility records:**

- Staff Time Sheets, Schedules, etc.
- Facility Internal Investigation Reports
- Facility Policies and Procedures

Number of additional resident(s) reviewed: Zero

Were residents selected based on the allegation(s)?  Yes  No  N/A

Specify: \_\_\_\_\_

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

Yes  No  N/A

Specify: Client #1 and Client #2 were present and Client #3 was not present

**Interviews: The following interviews were conducted during the investigation:**

Interview with reporter(s)  Yes  No  N/A

Specify: \_\_\_\_\_

If unable to contact reporter, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:
_____	_____	_____	_____	_____	_____

Interview with family:  Yes  No  N/A Specify: \_\_\_\_\_

Did you interview the resident(s) identified in allegation:

Yes  No  N/A Specify: \_\_\_\_\_

Did you interview additional residents?  Yes  No

Total number of resident interviews: One

Facility Name: Delphi

Report Number: HG211003

Interview with staff:  Yes  No  N/A Specify: \_\_\_\_\_

**Tennessee Warnings**

Tennessee Warning given as required:  Yes  No

Total number of staff interviews: Seven

Physician Interviewed:  Yes  No

Nurse Practitioner Interviewed:  Yes  No

Physician Assistant Interviewed:  Yes  No

Interview with Alleged Perpetrator(s):  Yes  No  N/A Specify: Not Identified

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:
_____	_____	_____	_____	_____	_____

If unable to contact was subpoena issued:  Yes, date subpoena was issued \_\_\_\_\_  No

Were contacts made with any of the following:

Emergency Personnel  Police Officers  Medical Examiner  Other: Specify \_\_\_\_\_

**Observations were conducted related to:**

Nursing Services

Facility Tour

Was any involved equipment inspected:  Yes  No  N/A

Was equipment being operated in safe manner:  Yes  No  N/A

Were photographs taken:  Yes  No Specify: \_\_\_\_\_

cc:

**Health Regulation Division - Licensing & Certification**

**The Office of Ombudsman for Mental Health and Developmental Disabilities**

**Shakopee Police Department**

**Scott County Attorney**

**Shakopee City Attorney**

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/05/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24G211</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/31/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>DELPHI</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1411 EAST SHAKOPEE AVENUE SHAKOPEE, MN 55379</b>		
(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) COMPLETION DATE	
W 000	INITIAL COMMENTS  A complaint investigation was conducted to investigate case #HG211300. Delphi is in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities.	W 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01228</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/31/2017</b>
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5 000	<p><b>Initial Comments</b></p> <p>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.</p> <p>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.</p> <p>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. A complaint investigation was conducted to investigate case #HG211003. As a result, the following correction orders are issued.</p>	5 000	<p>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 out of compliance is listed in the</p>	

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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5 000	Continued From page 1	5 000	<p>"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."</p> <p>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.</p>	
5 700	<p>MN Statute 144.651 Subd. 14. RES. RIGHTS Freedom from maltreatment.</p> <p>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 nontherapeutic 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 nontherapeutic 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.</p>	5 700		

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5 700	<p>Continued From page 2</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure two of two residents (R1, R2) were free from maltreatment when the facility did not provide adequate supervision of R3. R1 and R2 were harmed when R3 entered the bedroom of R1 and R2, touching R1 on the chest and R2 on the pelvis. This practice had the potential to affect all eight residents currently residing in the facility.</p> <p>Findings include:</p> <p>The facility's Client Protections policy revised July 15, 2017, indicated adults who because of physical or mental disability or dependency on facility services were particularly vulnerable to maltreatment. The facility would provide safe residential services and a safe living environment for vulnerable adults and would take immediate action regarding maltreatment. The facility would train and supervise the employees charged with the care of vulnerable adults to provide a safe living environment. This would be accomplished through policies and procedures designed to protect the vulnerable adults.</p> <p>R1's medical record was reviewed. R1's Individual Abuse Prevention Plan (IAPP) revised April 25, 2017, indicated R1 would likely seek or cooperate in an abusive situation due to sexual interest and desire. R1's guardians felt it would be inappropriate for R1 to have a sexual relationship with one of her housemates.</p> <p>R2's medical record was reviewed. R2's Individual Abuse Prevention Plan revised March 3, 2017, indicated R2 would likely seek or</p>	5 700		

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5 700	<p>Continued From page 3</p> <p>cooperate in an abusive situation. R2 had expressed her affection towards others in ways that show a lack of boundaries. If someone else was showing interest in R2, she may not say no or feel there was anything wrong with what happened.</p> <p>R3's medical record was reviewed. R3's comprehensive functional assessment dated 1/5/17, indicated R3 was ambulatory and could communicate his needs. R3 had an incident where the program director filed a vulnerable adult report to the state agency in February 2017 indicating R3 touched R1 inappropriately and wrote his name on R2's breasts. R3's Individual Abuse Prevention Plan revised March 3, 2017, indicated R3 lacked an understanding of sexuality. R3 was likely to seek out a sexual situation or cooperate in an abusive situation. R3 might comply in a sexual situation as he had a high interest in sexuality. R3 may coerce or take advantage of others due to interest in sexuality and wanting to have a girlfriend. R3's measures to minimize the risk for abuse included: staff would provide R3 with informal training and discussions about what is appropriate, recognizing boundaries, asking other people how they feel or what they want, knocking when he wants to talk to someone that is in their room, and respecting other individual's privacy as well as his own. A referral was made for R3 to receive therapy sessions to discuss boundaries and appropriate interactions. A referral was made for R3 to receive interventions to minimize issues with boundaries around sexuality.</p> <p>R3's metro crisis program considerations dated April 2017, indicated R3 was diagnosed with moderate intellectual disabilities and Down syndrome.</p>	5 700		

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5 700	<p>Continued From page 4</p> <p>The client information worksheet revised August 31, 2017, indicated R1 and R2 were diagnosed with moderate intellectual disabilities.</p> <p>An interview was conducted with the program director on October 13, 2017, at 1:08 p.m. The program director stated both R1 and R2 reported in separate interviews that R1 had entered their room while both R1 and R2 were in bed on 9/25/17. R1 stated R3 had touched her chest area and back. R2 stated R3 touched her pelvic area. R2 told R3 to leave the room and he did. The program director stated she believed the incident happened quickly as the evening staff had no awareness R3 was in their room. The program director stated they did not know what time the incident occurred. R1 reported the incident to staff the next morning. The program director stated after the February 2017, incident R3 was referred to metro crisis for an assessment. R3 was referred to the county and received a circle program that identified boundaries to be used with family and boundaries to be used with housemates. The staff were told they needed to know the location of R3 when he was in the house. R1 and R2 were given whistles and were trained to blow the whistle if anyone came into their room unwanted or if they felt unsafe. The program director stated R1 and R2 did not blow their whistles when the incident occurred in September.</p> <p>An interview was conducted with direct care staff (DC)-D on October 13, 2017, at 2:41 p.m. DC-D stated she herself goes to bed about midnight when working the night shift and then checks on the clients at 1:30 a.m., 3:30 a.m., and 5:30 a.m.</p> <p>An interview was conducted with R1's guardian</p>	5 700		

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5 700	<p>Continued From page 5</p> <p>on October 17, 2017, at 3:14 p.m. The guardian stated when the second incident occurred she was concerned about nighttime supervision.</p> <p>An interview was conducted with direct care staff (DC)-I on October 19, 2017, at 8:05 a.m. DC-I stated she was working the night shift alone on September 25, 2017, and there were nine clients in the house. DC-I stated she did three checks on the clients at night and then she was allowed to sleep in the staff room. The staff room was located on the second floor in between the resident's bedrooms. DC-I stated she was instructed by the program director that if R3 was not with staff they need to know his whereabouts. DC-I stated during the night shift there were times she had to be in other resident's rooms providing care which could take up to five minutes.</p> <p>An interview was conducted with R3's guardian on October 19, 2017, at 10:01 a.m. The guardian stated she was told by the program director that R3 would need to be picked up on September 26, 2017, and taken to her house until other arrangements could be made for the safety of all the clients.</p> <p>An interview was conducted with R2's guardian on October 19, 2017, at 3:38 p.m. The guardian stated when the first incident occurred in February 2017, she gave the facility the benefit of the doubt. The guardian stated after the second incident she felt R3 needed to be discharged from the facility.</p> <p>An interview was conducted with direct care staff (DC)-J on October 23, 2017. DC-J stated she was hired in April of 2017, and did provided care to R1, R2, and R3. DC-J stated R3 did like R1. DC-J stated she was to watch R3 and his</p>	5 700		

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5 700	<p>Continued From page 6</p> <p>boundaries. DC-J stated the morning after the September incident, R1 told her R3 came into her room and turned on the air conditioning. R1 reported R3 had patted her chest and back. R2 then reported R3 had touched her and pointed to the front of her legs.</p> <p>An interview was conducted with the program director on October 31, 2017, at 11:01 a.m. The program director stated the staff were to ensure that R3 was not left alone on the same floor as R1 and R2 in the two-story-house without staff present.</p> <p>Time Period for Correction: Twenty-one (21) days.</p>	5 700		
5 895	<p>MN Statute 626.557 Subd. 14. VA Abuse prevention plans.</p> <p>(a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.</p> <p>(b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2)</p>	5 895		

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5 895	<p>Continued From page 7</p> <p>the person's risk of abusing other vulnerable adults; and</p> <p>(3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.</p> <p>(c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to accurately identify the person's risk of abusing other vulnerable adults (VA) and the specific measures to be taken to minimize the risk of abuse to other vulnerable adults for 1 of 3 clients (C3) whose VA plans were reviewed. C3 had a history of sexual abuse towards C1 and C2. This practice had the potential to affect all eight clients currently residing in the facility.</p> <p>Findings include:</p> <p>The program director filed a vulnerable adult</p>	5 895		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01228</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/31/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DELPHI</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1411 EAST SHAKOPEE AVENUE SHAKOPEE, MN 55379</b>
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5 895	<p>Continued From page 8</p> <p>report to the state agency in February 2017. The report indicated on 2/19/17, that C3 had touched C1 in an inappropriate manner. The second report indicated C3 had written his name on C1's breasts.</p> <p>C3's medical record was reviewed. C3's Individual Abuse Prevention Plan revised March 3, 2017, indicated C3 lacked an understanding of sexuality. C3 was likely to seek out a sexual situation or cooperate in an abusive situation. C3 might comply in a sexual situation as he had a high interest in sexuality. C3 may coerce or take advantage of others due to interest in sexuality and wanting to have a girlfriend. C3's measures to minimize the risk for abuse included: staff would provide C3 with informal training and discussions about what is appropriate, recognizing boundaries, asking other people how they feel or what they want, knocking when he wants to talk to someone that is in their room, and respecting other individual's privacy as well as his own. A referral was made for C3 to receive therapy sessions to discuss boundaries and appropriate interactions. A referral was made for C3 to receive interventions to minimize issues with boundaries around sexuality. However, the IAPP did not identify the incidents that occurred in February 2017, nor did it identify that staff were to know C3's whereabouts when he was on the same level as C1 and C2 in the two-story-house.</p> <p>C3's metro crisis program considerations dated April 2017, indicated C3 was diagnosed with moderate intellectual disabilities and Down syndrome.</p> <p>The client information worksheet revised August 31, 2017, indicated C1 and C2 were diagnosed with moderate intellectual disabilities.</p>	5 895		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01228</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/31/2017</b>
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5 895	<p>Continued From page 9</p> <p>The program director filed a vulnerable adult report to the state agency in September 2017. The report indicated C3 had entered the shared bedroom of C1 and C2. C3 touched C1 on her chest and back and C3 touched C2's pelvic area. However, this information was lacking from C3's IAPP as well.</p> <p>An interview was conducted with the program director on 10/31/17, at 11:01 a.m. The program director verified the specific supervision measures which included staff being with C3 when he was on the same level of the house with C1 and C2 was not identified in the VA plan. The program director also verified the sexual abuse incident that occurred in February 2017, between C1, C2 and C3 was not addressed in the VA plan.</p> <p>The facility policy titled Client Protections revised July, 15, 2015, indicated an Individual Abuse Prevention Plan (IAPP) would include an individualized assessment of the person's susceptibility to abuse other vulnerable adults and a statement of the measures that would be taken to minimize the risk of abuse to other vulnerable adults. The interdisciplinary team should document the review of all abuse prevention plans at least annually, using the individual assessment and any reports of abuse relating to the person. The plan shall be revised to reflect the results of this review.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	5 895		