Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
VOA Home Health at Elder Homestead
11400 4th Street North
Minnetonka, Minnesota 55343
Hennepin County

Report #: HL23500004

Date: September 5, 2014

Date of Visit: June 19, 2014
Time of Visit: 8:00 a.m. – 2:00 p.m.

By: Lisa Jacobsen, R.N., Special Investigator

Type of Facility:

- ☐ Nursing Home
- ☐ SLF
- ☐ Hospital
- ☐ HHA
- ☐ ICF/IID
- ☐ Other: ____________
- ☒ Home Care Provider/Assisted Living
- ☐ Home Care

☐ Facility Self Report ☒ Complaint

Allegation(s): **It is alleged** that Client #1was abused when an employee, alleged perpetrator (AP), had sexual intercourse with the client.

An unannounced visit was made at this facility and an investigation was conducted under:

- ☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
- ☐ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
- ☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
- ☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
- ☐ Federal Regulations for EMTALA (42 CFR Part 489)
- ☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
- ☐ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- ☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
- ☑ State Licensing Rules for Home Care (MN Rules Chapter 4668)

☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☑ Abuse ☐ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Based on a preponderance of evidence, sexual abuse occurred when the AP had sexual intercourse with Client #1, during a time when the client was taken off the secured memory care unit and was left unsupervised by the home care provider.

Client #1, who had a diagnosis of cognitive impairment initially resided on the assisted living portion of the building, but due to incidents of the client leaving the facility and delivering newspapers to neighbors and looking for a house to buy for her family, the client was moved to the secured memory care unit of the facility for the client's safety. Client #1 was forgetful, had impaired judgment, was disoriented daily and made attempts to leave the memory care unit. The client's Vulnerability Assessment indicated the client received twenty-four hour supervision on the memory care unit.

Shortly before 9:00 a.m., a licensed nurse escorted Client #1 and two other clients off the secured memory care unit to the screened porch at the front of the building, which was an unsecured area. Although the licensed nurse stated, she informed the receptionist that clients from the memory care unit were on the front porch, the receptionist did not recall this and left the front area of the facility to conduct a scheduled 9:00 a.m. tour of the building with a potential client. At approximately 9:45 a.m. – 10:00 a.m., the receptionist returned to the receptionist desk at the front of the building and noted one of the clients was walking into the front parlor. (This client was one of the two other clients that were brought to the front porch with Client #1 earlier.) The receptionist contacted the memory care unit staff, who discovered Client #1 was neither on the memory care unit nor on the front porch. Staff conducted a search of other areas of the building including outside. A short time later, the licensed nurse saw Client #1 walking down the hallway of the memory care unit. (It could not be determined how Client #1 got back into the secured memory care unit.)

Shortly after Client #1 was found, the client appeared worried and stated to the nurse that she was concerned that she might be having a baby. When questioned why she thought that, Client #1 stated she had sexual intercourse approximately ten minutes prior, and she did not know where she was in her menstrual cycle. Client #1 was unable to identify the person with whom she had sexual intercourse, but indicated it did not occur in her room on the memory care unit.

Client #1 was transferred to the emergency room. A sexual assault examination was conducted and laboratory samples were taken. The samples identified that semen was present.

DeoxyriboNucleic Acid (DNA) testing of the samples was conducted and the results matched the AP's DNA.

The AP was criminally charged with third degree sexual conduct.

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 comparative responsibility between the facility and the AP were reviewed and it was determined that both the AP and the facility were responsible for the abuse.

The AP is responsible for the sexual abuse. The facility had policies in place regarding abuse/neglect of a vulnerable Adult. The facility provided the AP with ongoing education related to Preventing, Recognizing and Reporting resident abuse. The AP did not follow professional standards in exercising professional judgment when he had sexual intercourse with a vulnerable adult.

The facility is responsible for the abuse. The sexual abuse occurred when Client #1 was taken off the secured memory care unit and left unsupervised in an unsecured location and the AP had sexual intercourse with the client. The facility failed to follow Client #1's plan for supervision to ensure the client's safety and was not in compliance with regulatory standards related to the client's supervision.

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:

State Licensing Rules for Home Care (MN Rules Chapter 4668) – Compliance Met
The facility was found to be in compliance with State Licensing Rules for Home Care (MN Rules Chapter 4668). No state licensing orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

State Statutes Chapters 144 & 144A – Compliance Not Met

The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: ____________
(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

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.

Minnesota Statutes, section 626.5572, subdivision 2 - Abuse
"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.

(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:

(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.

The Investigation included the following:

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

☒ Medical Records ☐ Care Guide

☒ Medication Administration Records

☒ Treatment Sheets

☒ Facility Incident Reports

☐ Physician Progress Notes

☒ ADL (Activities of Daily Living) Flow Sheets

☐ Laboratory and X-ray Reports

☒ Physician Orders

☐ Social Service Notes

☒ Nurses Notes

☐ Meal Intake Records

☐ Activities Reports

☐ Weight Records

☐ Therapy and/or Ancillary Services Records

☐ Assessments

☒ Skin Assessments

☒ Care Plan Records

<u>Other pertinent medical records</u>:

☒ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☐ Death Certificate

☐ Police Report

<u>Additional facility records</u>:

☐ Resident/Family Council Minutes

☒ Personnel Records/Background Check, etc.

☒ Staff Time Sheets, Schedules, etc.

☐ Facility In-service Records

☒ Facility Internal Investigation Reports

☒ Facility Policies and Procedures

☐ Call Light Audits

☐ Other, specify: __________

Number of additional resident(s) reviewed: 2

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: The client was staying with a family member.

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ◉ Yes ○ No ○ N/A Specify: ______

If unable to contact complainant, 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: The client was staying with a family member.

Did you interview additional residents: ○ Yes ◉ No

Total number of resident interviews: Six clients visited with, but unable to be interviewed due to cognitive deficits.

Interview with staff: ◉ Yes ○ No ○ N/A Specify: ______

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 11

Physician interviewed: ○ Yes ◉ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ◉ No ○ N/A Specify: The AP's attorney indicated the AP respectfully declined to be interviewed.

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:

☐ Wound Care ☐ Medication Pass ☐ Meals

☐ Personal Care ☐ Dignity/Privacy Issues ☐ Restorative Care

☐ Nursing Services ☒ Safety Issues ☒ Facility Tour

☐ Infection Control ☐ Cleanliness ☐ Injury

☐ Use of Equipment ☐ Transfers ☐ Incontinence

☐ Call Light ☐ Other: ________

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: ________

xc: Division of Compliance Monitoring - Licensing & Certification
Minnetonka City Police Department
Hennepin County Attorney
Minnetonka City Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H23500	A. BUILDING: ______ B. WING ______	C 07/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOA HOME HLTH AT ELDER HOMESTEAD	11400 4TH STREET NORTH MINNETONKA, MN 55343

(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 A complaint investigation was conducted to investigate case #HL23500004. The following correction order is issued. When corrections are completed please sign and date, make a copy of the form for your records and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Office of Health Facility Complaints; 85 East Seventh Place, Suite 220, P.O. Box 64970, St. Paul, Minnesota 55164-0970	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/Rules for Home Care Providers. 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 "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 surveyors ' 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/RULES.	
0 030	144A.44 Subd.1(2) Up-to-date Plan/Accepted Standards Practice Subdivision 1. Statement of rights. A person who receives home care services has these rights: (2) the right to receive care and services	0 030		

Minnesota Department of Health

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0 030	Continued From page 1 according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that care and services were provided according to an up-to-date plan regarding client supervision for three of three clients (C1, C2 and C3) reviewed who resided on the memory care unit of the facility. Findings included: Three memory care clients were taken off the locked memory care unit and left unsupervised for a period of approximately one hour and 20 minutes. C1's record was reviewed. C1's nurse assessment dated April 1, 2014 indicated the client was forgetful, was disoriented daily and lived in the memory care unit and would attempt to leave the unit. C1's Assessment for Client Vulnerability, Safety and Risk to Others dated April 1, 2014 indicated, "24 hr (hour) supervision in memory care unit." C2's and C3's records were reviewed. C2's and C3's Assessment for Vulnerability, Safety and Risk to Others dated March 29, 2014 and March 18, 2014 respectively indicated the clients were	0 030		

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0 030	Continued From page 2 oriented to self only, wandered and were appropriate for the memory care unit. A written statement undated written by Licensed Practical Nurse (LPN)-D indicated the following: On June 13, 2014, after breakfast, LPN-D escorted C1, C2 and C3, all clients of the memory care unit, to the four season screened porch at the front of the building. LPN-D indicated she informed the receptionist that the clients were out there and that she would be back in a little while to bring the clients back to the memory care unit. LPN-D went back to the memory care unit and escorted other memory care unit client's to the fenced patio area on the memory care unit. A short time later, the receptionist contacted LPN-D and asked if C1 was with her. LPN-D responded that C1 was not with her and went to the front porch area. The front of the building and common areas/restrooms were searched. When not able to find C1, LPN-D went back to the memory care unit and checked C1's apartment. After not finding C1 in her apartment, LPN-D went to check the fenced patio area on the memory care unit. When walking back from the patio, LPN-D saw C1 walking down the hallway of the memory care unit. A written statement dated June 13, 2014 written by the administrative assistant indicated the following: On June 13, 2014 shortly before 9:00 a.m. LPN-D brought C1, C2 and C3 from the memory care unit to sit in the screened in porch. At around 9:00 a.m., the administrative assistant gave a scheduled tour of the building to a potential client. The tour finished around 9:45 a.m. Around 9:50 a.m., the administrative assistant noticed C2 wandering into the front parlor. The administrative assistant checked on the other two clients in the screened in porch and	0 030		

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0 030	Continued From page 3 noticed C1 was no longer on the porch. A search began. for C1. Around 10:20 a.m., LPN-D indicated that she had found C1. When interviewed June 19, 2014 at 12:40 p.m., the administrative assistant stated on June 13, 2014 just before her 9:00 a.m. tour, LPN-D brought C1, C2 and C3 to sit in the screened porch. The administrative assistant stated this was not unusual for these clients to be brought from the memory care unit and sit in the screened porch area. LPN-D did not say anything to the administrative assistant when she brought the clients out to the screened porch. The administrative assistant's scheduled tour arrived and the she left her desk area and took the potential client on a tour of the building. The administrative assistant stated around 9:45-10:00 a.m., she returned from the tour and saw C2 wondering in the parlor area. The administrative assistant checked the porch and only C3 was there. A search for C1 began. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 030		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
H23500	A. Building B. Wing	9/30/2014

Name of Facility	Street Address, City, State, Zip Code
VOA HOME HLTH AT ELDER HOMESTEAD	11400 4TH STREET NORTH MINNETONKA, MN 55343

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 00030 Reg. # 144A.44 Subd.1(2) LSC	Correction Completed 09/30/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/14/2014			