



Minnesota Department of Health

Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name: State Operate Psychiatric Nursing Facility St Peter			Report Number: HL25494010	Date of Visit: February 15, 2017
Facility Address: 100 Freeman Drive			Time of Visit: 9:30 a.m. to 4:30 p.m.	Date Concluded: May 2, 2017
Facility City: St Peter			Investigator's Name and Title: Deborah Neuberger, RN, Special Investigator	
State: Minnesota	ZIP: 56082	County: Nicollet		

Nursing Home

Allegation(s):

It is alleged that a resident was neglected when facility staff failed to provide adequate supervision resulting in sexual touching by another resident.

- State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- 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 of supervision is substantiated. The facility failed to adequately supervise Resident #1 when he exhibited sexually inappropriate behavior with another resident. Resident #1 then exhibited sexually inappropriate behavior with other residents on three additional occasions.

Resident #1 was admitted in 2015. Resident #1's diagnoses included Parkinson's disease. Resident #1 had a history of antisocial personality disorder and paraphilia (obsession with unusual sexual practices). Resident #1's plan of care indicated Resident #1 was at risk for abusing others, had a history of being a predatory offender, and was at risk for being sexually exploited by others. The interventions and approaches for these problems included: hourly safety checks, staff monitoring for inappropriate behaviors and aggression toward others, and staff to intervene as necessary.

Resident #2 was admitted in 2015. Resident #2's diagnoses included chronic inflammatory demyelinating polyneuropathy and HIV. His plan of care indicated he was at risk for abusing others, had a history of sexual offenses against vulnerable male adults, had a history of not informing intimate partners of his HIV status, and was at risk for retaliation from peers secondary to his intrusive behaviors. The interventions and approaches for these problems included: hourly checks, with staff to observe, report, and intervene with any inappropriate interactions on the unit.

Resident #3 was admitted in 2013. Resident #3's diagnoses included dementia, stroke, and epilepsy. Resident #3's care plan revealed he was at risk for abuse from others.

Resident #4's admission occurred in 2017. Resident #4's diagnoses included dementia and Parkinson's disease.

During 2016, staff observed Resident #1 and Resident #2 engaging in sexual behavior two times. No new interventions, or other updates to either resident's care plans, were implemented after these two incidents.

Within a two week period, Resident #1 touched Resident #3 and Resident #4 in a sexually aggressive manner. Nursing staff initiated one-on-one staffing for Resident #1 after these incidents, which was discontinued the following day, after Resident #1 agreed not to touch anyone that day. No ongoing changes were made to Resident #1's care plan related to supervision.

Interviews with nursing staff revealed a staff member sent an email asking about increasing Resident #1's supervision level in response to the allegations that Resident #1 was sexually touching multiple other residents. There was no response to the email, so Resident #1's supervision level was not increased.

During an interview, the administrator stated Resident #1's care plan was briefly changed, for less than one day, to one-on-one observation. The administrator could not state why this increased supervision was discontinued. Resident #1's care plan related to supervision has not been changed since Resident #1 has been observed and/or reported to be sexually touching multiple other residents.

During an interview, Resident #1 denied sexually touching other residents.

Interviews with the responsible party for Resident #1 and Resident #2 revealed neither resident had verbalized any concern about their treatment at the facility.

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:

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 ensure staff followed policies and procedures related to protecting vulnerable adults. Despite multiple reports that a resident was engaging in unwanted sexual touching of other residents, additional assessment or interventions were not implemented.

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 Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: Yes No

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

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 Statutes 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:

Facility Corrective Action:

The facility took the following corrective action(s):

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.

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
- Medication Administration Records
- Nurses Notes
- Assessments
- Physician Orders
- Physician Progress Notes
- Care Plan Records
- Social Service Notes
- Facility Incident Reports

Other pertinent medical records:

- Police Report

Additional facility records:

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

Number of additional resident(s) reviewed: Three

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: _____

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: _____

Did you interview additional residents? Yes No

Total number of resident interviews: Two

Interview with staff: Yes No N/A Specify: _____

Tennessee Warnings

Tennessee Warning given as required: Yes No

Total number of staff interviews: Nine

Physician Interviewed: Yes No

Nurse Practitioner Interviewed: Yes No

Physician Assistant Interviewed: Yes No

Interview with Alleged Perpetrator(s): Yes No N/A Specify: _____

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:

Was any involved equipment inspected: Yes No N/A

Facility Name: State Operate Psychiatric
Nursing Facility St Peter

Report Number: HL25494010

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

Were photographs taken: Yes No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Mental Health and Developmental Disabilities

The Office of Ombudsman for Long-Term Care

St Peter Police Department

Nicollet County Attorney

St Peter City Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/01/2017
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NAME OF PROVIDER OR SUPPLIER STATE OPERATED PSYCHIATRIC NURSING FA	STREET ADDRESS, CITY, STATE, ZIP CODE 100 FREEMAN DRIVE ST PETER, MN 56082
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</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 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.</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.</p> <p>INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #HL25494010. As a result, the following correction orders are issued.</p>	2 000	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 Nursing Homes.	

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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2 000	Continued From page 1	2 000	<p>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 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." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.</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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.</p>	
2 560	<p>MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents</p> <p>Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing,</p>	2 560		

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2 560	<p>Continued From page 2</p> <p>and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure an appropriate plan of care for 1 of 4 resident's reviewed (Resident #1 (R1)) when he exhibited sexually inappropriate behavior with a peer, and staff failed to adequately update his plan of care. R1 then exhibited sexually inappropriate behavior with peers on three additional occasions. Findings include:</p> <p>Medical record review revealed R1 was admitted to the facility in 2015 with diagnoses that included Parkinson's Disease. R1's history and physical, dated 3/29/2016, revealed R1 had a history of Antisocial Personality Disorder and Paraphilia (obsession with unusual sexual practices). R1's comprehensive Plan of Care, dated 8/4/2016, revealed R1 was at risk for abusing others and had a history of being a predatory offender, and was at risk for being sexually exploited by others. The interventions and approaches for these problems included: Hourly safety checks. Staff monitoring for inappropriate behaviors and aggression toward others. Staff will intervene as necessary.</p> <p>Medical record review revealed R2 was admitted to the facility in 2015 with diagnoses that included Chronic Inflammatory Demyelinating Polyneuropathy and HIV. R2's comprehensive Plan of Care, dated 6/3/2016, revealed R2 was at</p>	2 560		

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2 560	<p>Continued From page 3</p> <p>risk for abusing others, had a history of sexual offenses against vulnerable male adults, had a history of not informing intimate partners of his HIV status, and was at risk for retaliation from peers secondary to his intrusive behaviors. The interventions and approaches for these problems included: Hourly checks. Staff to observe, report, intervene with any inappropriate interactions on the unit.</p> <p>The document titled Internal Review of Maltreatment report, marked: Date of Incident: 7/12/2016 revealed R1 and R2 were witnessed sitting in the doorway of R2's room. R2's penis was exposed.</p> <p>During an interview on 2/15/2017 at 2:00 p.m., Human Services Support Specialist (HSS)-E stated last summer, exact date unknown, she was walking in the hall when she saw R1 and R2 at the doorway of R2's room. The two men had their legs entangled with one another, and R2's penis was exposed and his pants were down. HSS-E reported the incident to her supervisor.</p> <p>No update to either resident's care plan could be found after this incident.</p> <p>Nursing notes dated 12/17/2016 revealed R1 and R2 were observed by facility staff to be in an activity, and R2's right arm was up R1's shorts to the elbow. R2's arm was moving.</p> <p>During an interview on 2/15/2016 at 12:15 p.m. HSS-F stated she was walking by the dining room on 12/17/2016 at about 1:30 p.m. when she looked in the dining room, R1 and R2 were sitting next to one another and R1 was leaning to the side with his buttocks up, and R2's arm was up in R1's shorts, up to his elbow. HSS-F walked in</p>	2 560		

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2 560	<p>Continued From page 4</p> <p>and intervened and then reported the incident to her supervisor, Registered Nurse (RN)-D.</p> <p>During an interview on 2/15/2017 at 12:45 p.m., RN-D stated on 12/17/16, the residents were watching a movie and HSSS-F approached her stating R2 had his hand up inside R1's shorts and was penetrating him rectally with his finger. HSSS-F stated she separated the two men. RN-D stated she thought R1's medications may have been changed, but R1's care plan related to supervision was not changed. RN-D stated she sent an email about two weeks ago asking if R1's supervision should be increased related to increased allegations of a sexual nature for R1, but no one responded, so she did not update the care plan or initiate increased supervision for R1.</p> <p>No update to R1's Care Plan related to supervision of R1 or R2 could be found after this incident.</p> <p>R3 was admitted to the facility in 2013 with diagnoses that included Dementia, Stroke and Epilepsy. R3's Care Plan, undated, revealed R3 was at risk for abuse from others, and R3's primary language was not English.</p> <p>R3's nursing notes, dated 1/21/2017, revealed R3 was coming out of R1's room, yelling at R1. Staff spoke with R3 who stated R1 called him into R1's room, then touched R3's penis. R3 told him to stop and pushed R1's hand away. R3 stated R1 had touched his penis on multiple occasions, and R3 had to tell R1 to stop.</p> <p>No update to R1's Care Plan related to supervision of R1 could be found after this incident.</p>	2 560		

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2 560	<p>Continued From page 5</p> <p>R4 was admitted to the facility 2/8/2017 with diagnoses that included Dementia, and Parkinson's Disease. No care plan addressing R4's susceptibility for abuse could be located. R4's nursing note, dated 2/8/2017, revealed R4 stated R1 touched his groin while they were in the dining room. R4 stated "I'm not going to let anything happen, just watch."</p> <p>Nursing staff initiated 1:1 staffing for R1 after this incident.</p> <p>R1's psychiatry note, dated 2/9/2017, revealed nursing staff called the on-call provider around 4:05 p.m. on 2/8/2017, stating R4 approached nursing staff flustered and upset, stating R1 had touched R4's private parts. R1 has been accused multiple times of being sexually inappropriate with others. Nursing staff states they keep a very close eye on R1. R1 agreed to not touch anyone today. The 1:1 supervision was discontinued 2/9/2017.</p> <p>No other changes to R1's care plan related to supervision could be found.</p> <p>During an interview on 2/15/2017 at 11:10 a.m., Administrator (ADM)-A stated R1's care plan was briefly (less than one day) changed to 1:1 observation after the 2/8/2017 incident of sexual touching of R4, but the additional supervision was discontinued. ADM-A could not state why the increased supervision was discontinued. ADM-A stated the facility is trying to see if R1 can be transferred to a more appropriate facility, but R1's care plan related to supervision has not been changed after R1 has been observed and/or reported to be sexually touching multiple peers.</p>	2 560		
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2 560	Continued From page 6 The policy titled 2016 Abuse Prevention Plan revealed under Measures to Minimize Potential Abuse, 11. a. Resident care plans are modified to meet resident's needs. SUGGESTED METHOD OF CORRECTION: The Administrator or designee could update any appropriate policies, train staff related to the updated policies, and monitor for staff compliance with the updated policies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
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 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 interview and document review, the facility failed to ensure an appropriate plan of	21850		

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21850	<p>Continued From page 7</p> <p>care for 1 of 4 resident's reviewed (Resident #1 (R1)) when he exhibited sexually inappropriate behavior with a peer, and staff failed to adequately update his plan of care. R1 then exhibited sexually inappropriate behavior with peers on three additional occasions. Findings include:</p> <p>Medical record review revealed R1 was admitted to the facility in 2015 with diagnoses that included Parkinson's Disease. R1's history and physical, dated 3/29/2016, revealed R1 had a history of Antisocial Personality Disorder and Paraphilia (obsession with unusual sexual practices). R1's comprehensive Plan of Care, dated 8/4/2016, revealed R1 was at risk for abusing others and had a history of being a predatory offender, and was at risk for being sexually exploited by others. The interventions and approaches for these problems included: Hourly safety checks. Staff monitoring for inappropriate behaviors and aggression toward others. Staff will intervene as necessary.</p> <p>Medical record review revealed R2 was admitted to the facility in 2015 with diagnoses that included Chronic Inflammatory Demyelinating Polyneuropathy and HIV. R2's comprehensive Plan of Care, dated 6/3/2016, revealed R2 was at risk for abusing others, had a history of sexual offenses against vulnerable male adults, had a history of not informing intimate partners of his HIV status, and was at risk for retaliation from peers secondary to his intrusive behaviors. The interventions and approaches for these problems included: Hourly checks. Staff to observe, report, intervene with any inappropriate interactions on the unit.</p> <p>The document titled Internal Review of</p>	21850		

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21850	<p>Continued From page 8</p> <p>Maltreatment report, marked: Date of Incident: 7/12/2016 revealed R1 and R2 were witnessed sitting in the doorway of R2's room. R2's penis was exposed.</p> <p>During an interview on 2/15/2017 at 2:00 p.m., Human Services Support Specialist (HSSS)-E stated last summer, exact date unknown, she was walking in the hall when she saw R1 and R2 at the doorway of R2's room. The two men had their legs entangled with one another, and R2's penis was exposed and his pants were down. HSSS-E reported the incident to her supervisor.</p> <p>No update to either resident's care plan could be found after this incident.</p> <p>Nursing notes dated 12/17/2016 revealed R1 and R2 were observed by facility staff to be in an activity, and R2's right arm was up R1's shorts to the elbow. R2's arm was moving.</p> <p>During an interview on 2/15/2016 at 12:15 p.m. HSSS-F stated she was walking by the dining room on 12/17/2016 at about 1:30 p.m. when she looked in the dining room, R1 and R2 were sitting next to one another and R1 was leaning to the side with his buttocks up, and R2's arm was up in R1's shorts, up to his elbow. HSSS-F walked in and intervened and then reported the incident to her supervisor, Registered Nurse (RN)-D.</p> <p>During an interview on 2/15/2017 at 12:45 p.m., RN-D stated on 12/17/16, the residents were watching a movie and HSSS-F approached her stating R2 had his hand up inside R1's shorts and was penetrating him rectally with his finger. HSSS-F stated she separated the two men. RN-D stated she thought R1's medications may have been changed, but R1's care plan related to</p>	21850		

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NAME OF PROVIDER OR SUPPLIER STATE OPERATED PSYCHIATRIC NURSING FA	STREET ADDRESS, CITY, STATE, ZIP CODE 100 FREEMAN DRIVE ST PETER, MN 56082
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21850	<p>Continued From page 9</p> <p>supervision was not changed. RN-D stated she sent an email about two weeks ago asking if R1's supervision should be increased related to increased allegations of a sexual nature for R1, but no one responded, so she did not update the care plan or initiate increased supervision for R1.</p> <p>No update to R1's Care Plan related to supervision of R1 or R2 could be found after this incident.</p> <p>R3 was admitted to the facility in 2013 with diagnoses that included Dementia, Stroke and Epilepsy. R3's Care Plan, undated, revealed R3 was at risk for abuse from others, and R3's primary language was not English.</p> <p>R3's nursing notes, dated 1/21/2017, revealed R3 was coming out of R1's room, yelling at R1. Staff spoke with R3 who stated R1 called him into R1's room, then touched R3's penis. R3 told him to stop and pushed R1's hand away. R3 stated R1 had touched his penis on multiple occasions, and R3 had to tell R1 to stop.</p> <p>No update to R1's Care Plan related to supervision of R1 could be found after this incident.</p> <p>R4 was admitted to the facility 2/8/2017 with diagnoses that included Dementia, and Parkinson's Disease. No care plan addressing R4's susceptibility for abuse could be located. R4's nursing note, dated 2/8/2017, revealed R4 stated R1 touched his groin while they were in the dining room. R4 stated "I'm not going to let anything happen, just watch."</p>	21850		

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21850	<p>Continued From page 10</p> <p>Nursing staff initiated 1:1 staffing for R1 after this incident.</p> <p>R1's psychiatry note, dated 2/9/2017, revealed nursing staff called the on-call provider around 4:05 p.m. on 2/8/2017, stating R4 approached nursing staff flustered and upset, stating R1 had touched R4's private parts. R1 has been accused multiple times of being sexually inappropriate with others. Nursing staff states they keep a very close eye on R1. R1 agreed to not touch anyone today. The 1:1 supervision was discontinued 2/9/2017.</p> <p>No other changes to R1's care plan related to supervision could be found.</p> <p>During an interview on 2/15/2017 at 11:10 a.m., Administrator (ADM)-A stated R1's care plan was briefly (less than one day) changed to 1:1 observation after the 2/8/2017 incident of sexual touching of R4, but the additional supervision was discontinued. ADM-A could not state why the increased supervision was discontinued. ADM-A stated the facility is trying to see if R1 can be transferred to a more appropriate facility, but R1's care plan related to supervision has not been changed after R1 has been observed and/or reported to be sexually touching multiple peers.</p> <p>The policy titled 2016 Abuse Prevention Plan revealed under Measures to Minimize Potential Abuse, 11. a. Resident care plans are modified to meet resident's needs.</p> <p>SUGGESTED METHOD OF CORRECTION: The Administrator or designee could update any appropriate policies, train staff related to the updated policies, and monitor for staff compliance with the updated policies.</p>	21850		

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21850	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21850		
21980	<p>MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults</p> <p>Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:</p> <p>(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or</p> <p>(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).</p> <p>(b) A person not required to report under the provisions of this section may voluntarily report as described above.</p> <p>(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.</p> <p>(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.</p> <p>(e) A mandated reporter who knows or has reason to believe that an error under section</p>	21980		

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21980	<p>Continued From page 12</p> <p>626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report an allegation of maltreatment for two of four resident's reviewed, Resident #1 (R1), when staff reported witnessing R2 with his hand up R1's shorts and was fondling him. Findings include:</p> <p>Medical record review revealed R1 was admitted to the facility in 2015 with diagnoses that included Parkinson's Disease. R1's history and physical, dated 3/29/2016, revealed R1 had a history of Antisocial Personality Disorder and Paraphilia (obsession with unusual sexual practices). R1's comprehensive Plan of Care, dated 8/4/2016, revealed R1 was at risk for abusing others and had a history of being a predatory offender and was at risk for being sexually exploited by others. The interventions and approaches for these problems included: Hourly safety checks. Staff monitoring for inappropriate behaviors and aggression toward others. Staff will intervene as</p>	21980		

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21980	<p>Continued From page 13</p> <p>necessary.</p> <p>Medical record review revealed R2 was admitted to the facility in 2015 with diagnoses that included Chronic Inflammatory Demyelinating Polyneuropathy and HIV. R2's comprehensive Plan of Care, dated 6/3/2016, revealed R2 was at risk for abusing others and had a history of sexual offenses against vulnerable male adults and a history of not informing intimate partners of his HIV status, and was at risk for retaliation from peers secondary to his intrusive behaviors. The interventions and approaches for these problems included: Hourly checks. Staff to observe, report, intervene with any inappropriate interactions on the unit.</p> <p>Nursing notes, dated 12/17/2016, revealed R1 and R2 were observed by facility staff to be in an activity and R2's right arm was up R1's shorts to the elbow. R2's arm was moving.</p> <p>During an interview on 2/15/2016 at 12:15 p.m., HSSS-F stated she was walking by the dining room on 12/17/2016 at about 1:30 p.m. when she looked in the dining room, R1 and R2 were sitting next to one another and R1 was leaning to the side with his buttocks up, and R2's arm was up in R1's shorts, up to his elbow. HSSS-F walked in and intervened and then reported the incident to her supervisor, Registered Nurse (RN)-D.</p> <p>During an interview on 2/15/2017 at 12:45 p.m., RN-D stated on 12/17/16, the residents were watching a movie and HSSS-F approached her stating R2 had his hand up inside R1's shorts and was penetrating him rectally with his finger. HSSS-F stated she separated the two men. RN-D stated she did not report the incident to her supervisor, or document the incident because this</p>	21980		

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21980	<p>Continued From page 14</p> <p>was not the first time there had been sexual engagement between these two residents and she thought the activity was consensual.</p> <p>During an interview on 2/15/2017 at 11:10 a.m., Administrator (ADM)-A stated the incident between R1 and R2 happened on 12/17/2016, but it was not reported to the appropriate state agency until Monday, 12/19/16.</p> <p>The policy titled Maltreatment of Vulnerable Adults, Reporting of, dated 10/6/2015 revealed under Procedure A. 1. All mandated reporters are required to make a report of any incident of observed or suspected maltreatment of a patient immediately (within 24 hours.)</p> <p>SUGGESTED METHOD OF CORRECTION: The Administrator or designee could update any appropriate policies, train staff related to the updated policies, and monitor for staff compliance with the updated policies.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	21980		



Protecting, Maintaining and Improving the Health of All Minnesotans

August 25, 2017

Ms. Michelle Chalin, Administrator
State Operated Psychiatric Nursing Facility-St Peter
100 Freeman Drive
St Peter, MN 56082

RE: Complaint Number HL25494010

Dear Ms. Chalin :

On August 1, 2017 an investigator of the Minnesota Department of Health, Office of Health Facility Complaints completed a re-inspection of your facility, to determine correction of orders found on the complaint investigation completed on March 1, 2017 with orders received by you on March 31, 2017. At this time these correction orders were found corrected and are listed on the attached State Form.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Matthew Heffron'.

Matthew Heffron, JD, NREMT
Health Regulations Division
Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 281-9796

MH/ja
Enclosure

cc: Home Health Care Assisted Living File
Nicollet County Adult Protection
Office of Ombudsman
MN Department of Human Services