DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL28733003M
Compliance #: HL28733004C

Date Concluded: March 2, 2021
Date of Visit: January 28, 2021
January 29, 2021

Name, Address, and County of Licensee Investigated:
Zumbro House
525 Commons Drive
Woodbury, MN 55125
Washington County

Name, Address, and County of Housing with Services location:
The Wings of Newport
2300 Hastings Avenue
Newport, MN 55055
Washington County

Facility Type: Home Care Provider

Investigator's Name:
Carrie Euerle MPH, MSN, RN
Special Investigator

Finding: Substantiated, facility and individual responsibility

Nature of Visit:
An unannounced visit was conducted to investigate an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):
It is alleged that a client was abused by a staff member/alleged perpetrator (AP) when the AP pushed her breasts in the client's face and stated, "I can make you love me." This incident occurred multiple times.

Investigative Findings and Conclusion:
Abuse was substantiated. The facility and the alleged perpetrator (AP) were responsible for the maltreatment. The AP engaged in sexual contact with the client when she put her breasts on the client. During this investigation, allegations of verbal abuse and resident to resident altercations involving the client were also investigated and found not substantiated.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. Observations, record and policy review as well as client interviews were completed during the onsite visit.

The client was admitted to the facility with diagnoses which included hypertension, chronic pain and depression. Upon admission, facility staff assessed the client and determined the client was alert and oriented to person, place, time, and situation. The facility identified on the client's vulnerability risk assessment that the client was able to report abuse accurately and consistently.

The client was interviewed and indicated that he felt targeted, uncomfortable, and sexually harassed by the AP. The client stated the AP would bend over and put her breasts on the client's shoulder and say "I'm gonna make you love me". The client indicated he had reported his concerns with the AP to staff and facility administration but felt no follow up had occurred.

Staff interviews completed during the onsite investigation supported the client's report of the AP's behavior toward the client. Staff interviewed indicated that the nurse and/or administration were aware of the client's report of the AP's behavior.

Facility administration denied any knowledge of the client's concern with the AP's behavior. No report of the allegations were identified in the facility's documentation.

During staff and client interviews, further concerns were identified regarding the AP. These concerns included instances of drinking alcohol with a client, working while impaired, falling asleep in the medication room, and having a sexual relationship with another client. Facility administration was questioned on these incidents and indicated knowledge of the events. However, none of these incidents had been reported or investigated as possible maltreatment, despite the AP being terminated from her position due to violations of the facility drug and alcohol policy.

Several attempts to contact the AP were unsuccessful.

In conclusion, abuse was substantiated. The AP engaged in sexual contact with the client by intentionally placing her intimate parts in contact with the client, with apparent sexual intent. The facility is also responsible for the abuse because the facility systematically failed to document, investigate, report, or follow-up on concerns from the client and others regarding the AP's behavior and other issues. Licensing orders were issued in relation to maltreatment, reporting of maltreatment, and additional violations identified during the onsite investigation.

Abuse: Minnesota Statutes section 626.5572, subdivision 2
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;

(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No, client is own responsible party.
Alleged Perpetrator interviewed: No, requests for interview were not returned. The AP was unable to be contacted for interview.

Action taken by facility:
No action was taken by the facility in relation to this allegation of abuse, however the AP was later terminated in relation to violations of facility policies unrelated to this incident.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit
http://www.health.state.mn.us/divs/fpc/directory/surveyapp/provcompselect.cfm, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the

Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
Health Regulation Division – Home Care and Assisted Living Program
The Office of Ombudsman for Long-Term Care
Washington County Attorney
Newport City Attorney
Washington County Sheriff's Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28733	A. BUILDING: ______ B. WING ______	C 01/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBRO HOUSE INC	**525 COMMONS DRIVE WOODBURY, MN 55125**

(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 ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On January 28 and January 29, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL28733003M/HL28733004C . The following correction orders are issued for #HL28733003M/HL28733004C, tag identification 0315, 0325, 0805, 2015, 2030. At the time of the investigation, there were 80 clients receiving services under the comprehensive license.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the investigators ' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested?for licensing order follow-ups. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
0 315 SS=I	144A.44, Subd. 1(a)(12) Served by People Who Are Competent	0 315		

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0 315	Continued From page 1 Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (12) be served by people who are properly trained and competent to perform their duties; This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 80 of 80 clients were served by staff who were competent to perform their duties when a staff member became intoxicated during her shift at the facility, was sent home and later returned to complete a second shift at the facility, as a lead worker, later that evening and was found by staff sleeping in the medication room. In addition, when the nurse became aware of the staff member's behavior there was no internal or external reporting of the incident, no investigation into the incident and no re-education or re-training for staff regarding protocols for reporting or dealing with situations involving impaired staff. In addition, multiple staff were aware of an incident where an unlicensed staff member had sexual contact with a client (C1), and took no action to protect C1. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems	0 315		

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0 315	Continued From page 2 are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: Findings include: IMPAIRED STAFF MEMBER A report made to the state agency (SA) on 12/28/2020 included an allegation that a staff member "got drunk" at the facility and was later found sleeping in the medication room. During an onsite complaint investigation on 1/28/2021 the Director of Nursing (DON) was interviewed upon entrance and stated the facility had no grievances or complaints on file from the last three months and no formal vulnerable adult (VA) reports that had been filed in the last three months. An interview with a client (C1) on 1/28/2021 at 11:03 a.m. indicated that he was aware of an incident with a staff member (unlicensed personnel/ULP-I) who was caught in another client's room "drinking and fornicating" and was later fired for this behavior. C1 also reported he was sexually assualted by ULP-I and that ULP-I was inappropriate with other clients. C1 stated he had reported these concerns to staff and management but no follow up had been made regarding his concerns. The Director of Operations (DO) was interviewed on 1/28/2021 at 11:31 a.m. who stated she was unaware of any formal complaints that C1 had made regarding ULP-I. The DO stated she was unaware of any complaints regarding ULP-I being sexually inappropriate with C1 or any other clients. However, the DO did indicate that ULP-I	0 315		

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was sent home from the facility due to appearing intoxicated and was later terminated. The DO stated she was unaware of the details of the termination or incident surrounding the alleged intoxication involving ULP-I.

The Director of Nursing (DON) was interviewed on 1/28/2021 at 1:08 p.m. who stated she was called by a staff member (Unlicensed personnel/ULP-C) around 7:00 p.m. on 12/18/2020 who reported ULP-I was intoxicated at the facility. The DON stated she came to the facility and assessed ULP-I, and determined ULP-I was intoxicated. The DON stated she sent ULP-I home. During the interview with the DON, the DON indicated she later found out that ULP-I had been drinking with one of the clients (C2) and that ULP-I was in a relationship with another client (C3). The DON stated she had heard that ULP-I had returned to the faciliy after the DON had sent her home on 12/18/2020 and continued to work a night shift, but that this was a "rumor" and she had not been called by staff later in the evening of 12/18/2020-12/19/2020 so she did not know if ULP-I returned or if she worked again that evening. In addition, the DON stated she attempted to follow up with C2 and C3 regarding the rumors she heard regarding ULP-I but both clients swore at her so she did not continue to look into the allegations. The DON stated she did not file a VA report as she did not view the incident involving ULP-I's drinking and alleged involvment with C2 and C3 in that way. The DON confirmed she did not follow up into review of whether ULP-I returned to the facility or if she worked the night shift after being sent home. The DON indicated she had completed a statement regarding this incident and ULP-I was terminated after this incident and had not returned to the facility.

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0 315	Continued From page 4 Review of the DON's statement dated 12/19/2020 indicated the following regarding ULP-I: "Staff called me at home Saturday night around 7pm to report that [ULP-I] is drunk and high at work. I came into work to investigate the situation. [ULP-I] was on 3rd floor. I found her by the elevator. She was slurring her words, her eyes were red and half closed. She could not walk a straight line. I talked with her for about 10 minutes and I made the decision to send her home and I told her to go home. She left in her car. I found out the next day that she came back to work and worked her shift and stayed for the night shift. Staff reported to me that she was sleeping in the medication room on the floor all night. When I asked her to go home Saturday evening, she left with one of our residents in her car. She was driving him around to different places. She was also seen in another truck with one of our other residents. It was reported to me that she was in resident's apartment for quite awhile and [ULP-I] was telling the other charges that she wanted to have sex with male resident. Narcotics are also missing from Narcotic drawer." A second statement was included on the DON's statement which included the following: "On the evening of the 13th of December. Staff also called me to tell me [ULP-I] was in the medication room sleeping and they couldn't get in the medication room because she had the key. Staff was knocking on the door but she didn't wake up. I then came into work to unlock the medication room and wake [ULP-I] up. She was sleeping sitting up in a chair and was very difficult to wake up. She finally woke up after shaking her, she was confused and disorientated. I waited for her to fully wake up. She was very apologetic and she has been working a lot of	0 315		

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doubles. She was coherent and answering my questions correctly. I was going to send her home that day but I gave her a second chance".

ULP-I's timecard dated 12/18/2020 - 12/19/2020 was reviewed, which indicated ULP-I was punched in from 2:59 p.m. - 12:00 a.m. on 12/18/2020 and from 12:00 a.m.- 7:25 a.m. on 12/19/2020.

ULP-C was interviewed on 1/28/2021 at 2:10 p.m. and confirmed she was the staff member who contacted the DON regarding ULP-I's behavior on 12/18/2020. ULP-C stated she was not working the evening of 12/18/2020 but had came to the facilty to help a client (C2) with a plant as she had promised earlier in the day. ULP-C stated she arrived at the facilty between 5:30 p.m. and 6:30 p.m. and found ULP-I in her car with C2. ULP-C stated ULP-I waved her over to the car and told ULP-C she was drunk; ULP-I stated she had four tequila shots and a beer. ULP-C was concerned about ULP-I's behavior and convinced C2 and ULP-I to come back in to the facilty. ULP-C told C2 she was at the facility to assist him with his plant as promised and had C2 return to his room. ULP-C stated she then called another lead staff member (unlicensed personnel/ULP-H) and the DON regarding ULP-I's behavior and statement regarding drinking. ULP-C stated she remained at the facility until the DON arrived to speak with ULP-I. ULP-C stated after the DON arrived and spoke with ULP-I, ULP-I left in her car. ULP-C stated she recieved a text message that ULP-I returned later in the shift but did not recall any follow-up, if any, she completed regarding ULP-I returning to the facility.

ULP-C completed a statement regarding the 12/18/2020 incident with ULP-I. ULP-C's

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statement included the following information: ULP-C arrived at the facility and found ULP-I and C2 in ULP-I's car. ULP-I told ULP-C that she was "drunk and had got drunk on the job". ULP-C observed ULP-I "could barely open her eyes". After ULP-C had ULP-I and C2 return to the building, ULP-C observed alcohol and alcohol bottles in C2's room. ULP-C stated C2 was concerned about ULP-I, and that ULP-I wanted to "have sex" with C3; C2 asked ULP-C to go to C3's room to make sure ULP-I was not "making any mistakes." When ULP-C arrived at C3's room, she found ULP-I "flirting and talking to [C3] about her butt." ULP-C's statement indicated she tried to "help" ULP-I but she did not want her there so she left and returned to C2's room. ULP-C's statement indicated she then called ULP-G and the DON to report ULP-C's behavior.

ULP-E and ULP-F were interviewed on 1/28/2020 at 3:50 p.m. and confirmed they were also working the evening of 12/18/2020. ULP-E and ULP-F indicated they heard from other staff members that ULP-I was drunk during their shift. ULP-E and ULP-F stated the DON came to speak with ULP-I, and the DON and ULP-I left the facility. ULP-E and ULP-F stated ULP-I later returned to the facility and asked which staff member "snitched" on her. ULP-E and ULP-F stated they witnessed ULP-I later leave the facility with C3, and ULP-I told ULP-E and ULP-F that she was smoking marijuana with C3. ULP-E and ULP-F stated ULP-I stayed to work for the night shift as she was the only lead worker scheduled for the shift. ULP-E and ULP-F stated they told the oncoming night shift staff (ULP-G) about ULP-I's behavior. ULP-G later text ULP-E and ULP-F stating that ULP-I was "out of it" and "kept talking" during the shift and later fell asleep in the medication room.

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0 315	Continued From page 7 ULP-H was interviewed on 2/16/2021 at 2:13 p.m. and stated she received a phone call on 12/18/2020 from ULP-C that ULP-I was intoxicated and unable to perform her duties. ULP-H stated ULP-C called her regarding ULP-I's behavior as ULP-I had admitted she became intoxcated during her shift and was not cooperating with ULP-C. ULP-H then directed ULP-C to call the DON and stated she would come to the facility to meet ULP-C, ULP-I and the DON. ULP-H stated she arrived at the facility and the DON spoke with ULP-I and shortly after ULP-I, the DON and ULP-H left the facility. ULP-H stated when ULP-I left the facility a male was in the car with her but she was not sure of who the male was or if it was a client from the facility. ULP-H further stated she later heard that ULP-I returned to the facility and worked the overnight shift and fell asleep in the medication room. ULP-H stated she could not recall who she had heard this from but stated that it should have been reported. ULP-H indicated that the DON was aware of the incident with ULP-I and assumed this incident would be reported, but not aware of any further action taken. ULP-J was interviewed on 2/4/2021 at 12:23 p.m. and stated she worked the night shift 12/18/2020-12/19/2020. ULP-J confirmed ULP-I worked the night shift. ULP-J stated she was informed by other staff members that ULP-I had been drinking with residents and was intoxicated. ULP-J stated ULP-I "definately did seem impaired" and she fell asleep in the medication room. ULP-J stated she thought the DON was aware of ULP-I's behavior as she had heard the DON was at the facility earlier, and ULP-I told her that someone had "snitched" on her and talked about a text message she sent to the DON and	0 315		

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administrator. ULP-J stated ULP-I later fell asleep in the medication room towards the end of the shift and staff had to come back twice to try to wake ULP-I up who eventually woke up and opened the door for staff to pass medications. ULP-J stated ULP-I did not pass medications during the overnight shift and was unaware of, if any, services or what work ULP-I completed. ULP-J stated she heard ULP-I no longer worked at the facility following this incident.

A follow-up interview was completed with the DON on 1/29/2021 at 1:45 p.m. During the interview the DON again confirmed she was made aware of allegations of ULP-I drinking with clients, leaving with clients in her car after being sent home intoxicated, wanting to have a sexual relationship with a client, and narcotics missing after ULP-I was asleep in the medication room and did not report these allegations as she did not feel that these were reportable incidents. The DON confirmed ULP-I was assigned as the lead staff member on 12/18/2020 and that the DON had assessed ULP-I to be intoxicated and not competent to work on 12/18/2020 and that is why she sent her home. The DON could not provide an answer to why she did not further look into ULP-I's return to the facility or further alleged behavior with clients C2 and C3 on the evening of 12/18-12/19/2020 but stated she should not have been working at the facility after being sent home. The DON stated she felt ULP-I was being taken advantage of by the clients (C2,C3) and said she did not view the clients as vulnerable adults. The DON stated she had not recieved vulnerable adult reporting training upon hire and not aware this incident would constitute a vulnerable adult report. The DON did indicate she completed a statement regarding this incident and that human resources (HR) should have been aware of what

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had happened and that she thought she reported the incidents to the DO. The DON was questioned about her continued statement indicating a previous incident on 12/13/2020 where ULP-I was alseep in the medication room. The DON stated she wanted to give ULP-I a second chance and allowed ULP-I to continue to work her shift after falling asleep on 12/13/2020. The DON indicated that ULP-I was the "lead charge" and had been working multiple shifts. The DON confirmed she had not reported this concern at the time but allowed ULP-I to finish her shift with no additional supervision. When asked about what narcotics were missing, the DON could not recall specific narcotics and also stated she was unaware of any reporting requirements regarding missing narcotics and could not provide details on her follow up on the missing narcotics.

The facility was asked to provide reports of missing narcotics, however no report regarding missing narcotics was available surrounding the date of 12/13/2021 or regarding missing narcotics while ULP-I was working or passing medications.

Review of the DON's personnel file indicated she recieved vulnerable adult (VA) training on 1/20/2021.

C2 and C3 both declined to be interviewed.

C2's medical record was reviewed and indicated C2 was admitted to the facility on 9/01/2020 with diagnoses which included schitzoaffective disorder, hypertension, diabetes mellitus type II and substance dependence. C2's vulerability, safety and risk assessment dated 11/24/2020 indicated C2 was alert and oriented to person, place and time and able to provide accurate and

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consistent information.

C3's medical record was reviewed and indicated C3 was admitted to the facility on 9/01/2020 with diagnoses which included bipolar disorder, anxiety, PTSD, and depression. C3's vulerability, safety and risk assessment dated 9/1/2020 indicated C3 was alert and oriented to person, place and time and able to provide accurate and consistent information. C3's vulerability assessment included C3 had a history of marijuana use and identified vulnerabilities due to paranoia, anxiety, bipolar disorder, PTSD and depression. The assessment further indicated C3 was able to accurately report abuse and neglect.

ULP-I was terminated from the facility on 12/21/2020 due to a violation of the facility's drug and alcohol policy.

ULP-I was unavailable for interview.

ULP-I's employee file was reviewed and indicated ULP-I had recieved vulnerable adult training, professional boundaries and ethics training as well as the company's drug and alcohol policy upon hire.

A follow-up interview was completed with the DO on 2/17/2021 at 2:18 p.m. who stated she was unaware of the specifics of the incident regarding ULP-I being intoxicated and later termination. The DO indicated she assumed the DON and HR had handled the situation in accordance with the corporation's policies. The DO indicated she was unaware of the specifics of the incident and indicated the incident should have been filed as a VA report upon the DON learning about ULP-I's alleged actions of drinking with clients, the allegation of having a sexual relationship with a

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0 315	Continued From page 11 client, and missing narcotics, and an investigation should have been completed. The DO indicated she was unaware of ULP-I asleep in the medication room and missing narcotics, however stated ULP-I should have been disciplined in accordance with corporate procedures and the DON should have followed the appropriate steps to complete this action at the time the incident occurred. The DO further indicated the DON had recieved training regarding VA reporting as had all staff who work at the facility. The DO also indicated she was concerned that ULP-I had returned to the facility after being sent home, that staff did not further report this and allowed ULP-I to remain at the facility. The DO had not reviewed ULP-I's timecard and was unaware that ULP-I worked the night shift after being sent home the on the evening shift. The DO was unaware of the specifics of ULP-I's termination and if anyone had followed up on the specifics on the incident from human resources or corporate office regarding these allegations and based upon what was written in the statements provided from the DON and ULP-C. The facility's undated drug and alcohol policy indicated the "use of illegal drugs, misuse of legal drugs, chemical abuse or due to alcohol abuse is likely to result in the risk of harm to other employees, the impaired employee, or to third parties, such as persons served, customers or guests. Moreover, drug and alcohol abuse adversely affects employee morale and productivity." The facility's Vulnerable Adult Reporting and Investigation Policy dated January 2020 included that staff were expected to report any allegations of suspected maltreatment in accordance with state and federal laws and that allegations of	0 315		

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0 315	Continued From page 12 maltreatment would be investigated by the RN and Administrator and then consulted with the Director of Operations. The policy indicated all staff would be trained on reporting policies and procedures and upon report of maltreatment a written notice would be provided to the internal reporter of maltreatment on the follow up of the incident and an internal investigation would be conducted of the alleged incident. SEXUAL CONTACT BETWEEN STAFF MEMBER AND CLIENT A complaint was made to the state agency (SA) on 12/18/2020 which included an allegation of sexual abuse involving a client (C1) and a staff member who was putting her breasts in C1's face and wheelchair and stating "I can make you love me" three times over the last two weeks, causing C1 to feel uncomfortable at the facility. The complaint indicated these concerns were reported to the facility by C1 but nothing had been done. During an onsite complaint investigation on 1/28/2021 the Director of Nursing (DON) was interviewed upon entrance and stated the facility had no grievances or complaints on file from the last three months and no formal vulnerable adult (VA) reports that had been filed in the last three months. C1's medical record indicated C1 was admitted to the facility on 11/04/2020 with diagnoses which included hypertension, chronic pain and depression. C1's vulnerability assessment dated 11/05/2020 indicated C1 was alert and oriented to person, time, place and situation. The vulnerability assessment indicated C1 was not a risk for abuse or harm to others and was able to	0 315		

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report abuse by others and identified C1 as able to provide accurate information consistently.

During an interview on 1/28/2021 at 11:03 a.m., C1 stated he was sexually assaulted by ULP-I and that ULP-I was inappropriate with other clients. C1 said ULP-I had sexually harassed him; "she would come over and bend over and put her boobs on her shoulder" and say "I'm gonna make you love me." C1 further reported ULP-I was sexually inappropriate with other clients. C1 stated he had reported these concerns to staff and management but no follow up had been made regarding his concerns. C1 indicated he wanted to sue ULP-I for sexual harassment and said ULP-I had been fired from the facility due to being "drunk on the job." C1 further stated he did not feel safe at the facility and was looking into placement at a different facility.

Vulnerable adult (VA) reports dating back the last three months from the onsite date of 1/28/2021 were requested from the facility, however none were provided as there were no reports filed in the last three months.

ULP-D was interviewed on 1/28/2021 at 3:20 p.m. and indicated she was aware that C1 had concerns with ULP-I's behavior. ULP-D stated C1 did not like ULP-I because ULP-I hugged him and he did not like it; ULP-I said she would make C1 like it.

ULP-E and ULP-F were interviewed on 1/28/2021 at 3:50 p.m. and stated ULP-I was unprofessional and inappropriate to both staff and residents. ULP-E and ULP-F stated they were afraid to question ULP-I's behavior as she was their supervisor on the shift they worked (ULP-I was lead worker during their shifts). ULP-E and ULP-F

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stated C1 had told them that ULP-I "shook her tits in my face" and stated she was going to "make [C1]] love me." ULP-E and ULP-F stated C1 reported to them that he did not like ULP-I, and ULP-I was aware of this and was always trying to build a relationship with C1 saying she was going to make him like her.

ULP-H was also interviewed on 2/16/2021 at 2:13 p.m. who stated she was aware of C1's concerns involving ULP-I. ULP-H stated C1 had told her he was uncomfortable with ULP-I because of her an incident where she rubbed her breasts on his shoulder. C1 told ULP-H he was uncomfortable around ULP-I and wanted nothing to do with her and he felt disrespected. ULP-H indicated ULP-I was aware of how C1 felt and that she still continued to try to build a relationship with him and did not respect his wishes. ULP-H indicated that the DON was made aware of C1's concerns regarding ULP-I. ULP-H further indicated she had concerns with the DON and administration's follow up, because she knew knew these concerns were being reported but was not ever made aware of any follow up action taken.

Several attempts were made to contact ULP-I that were unsuccessful.

ULP-I's employee file was reviewed and indicated ULP-I had received vulnerable adult training, professional boundaries and ethics training upon hire.

C1's case manager was interviewed on 1/27/2021 at 2:36 pm a d indicated she was aware of C1's concerns related to ULP-I's behavior. The case manager indicated C1 had reported to her that ULP-I was sexually abusing him by pushing herself in his face. C1 reported he was at one

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0 315	Continued From page 15 point afraid to make a report to the nurse regarding ULP-I's behavior because ULP-I and the nurse were friends. The case manager indicated that she was aware ULP-I was later terminated due to unrelated inappropriate behavior and that C1's concerns with sexual abuse and ULP-I had been reported to the facility. The Director of Operations (DO) was interviewed on 1/28/2021 at 11:37 a.m. and indicated she was not aware of any concerns regarding ULP-I and C1 and not aware of any allegations of abuse including C1. The DON was interviewed on 1/28/2021 at 1:08 pm and stated she was unaware of any complaints or allegations of abuse by C1 involving ULP-I. The Executive Director (ED) was also interviewed on 1/28/2021 at and was unaware of any concerns or allegations of abuse involving C1 and ULP-I. In an interview with the ED on 1/29/2021 at 1:52 p.m. she confirmed that any allegations of abuse, neglect or maltreatment should be internally reported and reported to the state agency (SA) and/or police department immediately in accordance with the facility policy. The facility's Vulnerable Adult Reporting and Investigation Policy dated January 2020 included that staff were expected to report any allegations of suspected maltreatment in accordance with state and federal laws and that allegations of maltreatment would be investigated by the RN and Administrator and then consulted with the Director of Operations. The policy indicated all staff would be trained on reporting policies and	0 315		

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0 315	Continued From page 16 procedures and upon report of maltreatment a written notice would be provided to the internal reporter of maltreatment on the follow up of the incident and an internal investigation would be conducted of the alleged incident. TIME PERIOD FOR CORRECTION: Seven Days	0 315		
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 was abused. Findings include: On February 26, 2021, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that the facility and an individual staff person were responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of	0 325	No Plan of Correction (PoC) required. Please refer to the maltreatment public report for details.	

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0 325	Continued From page 17 evidence that maltreatment occurred.	0 325		
0 805 SS=F	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors Subd. 6.Reporting maltreatment of vulnerable adults and minors. (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care provider must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report incidents of suspected maltreatment of vulnerable adults and failed to implement the facility's written procedures to ensure that cases of suspected maltreatment are reported for 3 of 3 clients (C1, C2, and C3) reviewed for maltreatment. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). Findings include: During an onsite complaint investigation on	0 805		

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1/28/2021 the Director of Nursing (DON) was interviewed upon entrance and stated the facility had no grievances or complaints on file from the last three months and no formal vulnerable adult (VA) reports that had been filed in the last three months.

SEXUAL CONTACT
A complaint was made to the state agency (SA) on 12/18/2020 which included an allegation of sexual abuse involving a client (C1) and a staff member who was putting her breasts in C1's face and wheelchair and stating "I can make you love me" three times over the last two weeks, causing C1 to feel uncomfortable and targeted at the facility. The complaint said these concerns were reported to the facility but nothing had been done.

C1's medical record indicated C1 was admitted to the facility on 11/04/2020 with diagnoses which included hypertension, chronic pain and depression. C1's vulnerability assessment dated 11/05/2020 indicated C1 was alert and oriented to person, time, place and situation. The vulnerability assessment indicated C1 was not a risk for abuse or harm to others and was able to report abuse by others and identified C1 as able to provide accurate information consistently.

The client (C1) was interviewed on 1/28/2021 at 11:03 a.m. and reported he was sexually assualted by ULP-I and that ULP-I was inappropriate with other clients. C1 reported ULP-I had sexually harrassed him; "she would come over and bend over and put her boobs on her shoulder" and say "I'm gonna make you love me". C1 further reported ULP-I was sexually inappropriate with other clients. C1 stated he had reported these concerns to staff and management but no follow up had been made

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regarding his concerns. C1 indicated he wanted to sue ULP-I for sexual harrassmentand said ULP-I had been fired from the facility due to being "drunk on the job." C1 further stated he did not feel safe at the facility and was looking into placement at a different facility.

Vulnerable adult (VA) reports dating back the last three months from the onsite date of 1/28/2021 were requested from the facility, however none were provided as there were no reports filed in the last three months.

Staff interviews conducted indicated staff had knowledge of C1's report of sexual abuse by ULP-I:

- ULP-D was interviewed on 1/28/2021 at 3:20 p.m. and indicated she was aware that C1 had concerns with ULP-I's behavior. ULP-D stated C1 did not like ULP-I because ULP-I hugged him and he did not like it; ULP-I said she would make C1 like it.

- ULP-E and ULP-F were interviewed on 1/28/2021 at 3:50 p.m. and indicated ULP-I was unprofessional and inappropriate to both staff and residents. ULP-E and ULP-F stated they were afraid to question ULP-I's behavior as she was their supervisor; ULP-I was lead worker during their shifts. ULP-E and ULP-F stated C1 had told them that ULP-I "shook her tits in my face" and stated she was going to "make you love me". ULP-E and ULP-F stated C1 reported to them that he did not like ULP-I, and ULP-I was aware of that and always tried to build a relationship with C1 saying she was going to "make him" like her.

- ULP-H was interviewed on 2/16/2021 at 2:13 p.m. and stated she was aware of C1's concerns

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involving ULP-I. ULP-H stated C1 had told her he was uncomfortable with ULP-I because of her an incident where her breasts rubbed on his shoulder. C1 told ULP-H he was uncomfortable around ULP-I and wanted nothing to do with her and he felt disrespected. ULP-H indicated ULP-I was aware of how C1 felt and that she still continued to try to build a relationship with him and did not respect his wishes. ULP-H indicated that the DON was made aware of C1's concerns regarding ULP-I.

Several attempts were made to contact ULP-I but were not successful.

C1's case manager was interviewed on 1/27/2021 at 2:36 pm and indicated she was aware of C1's concerns related to ULP-I's behavior. The case manager indicated C1 had reported to her that ULP-I was sexually abusing him by pushing herself in his face. C1 reported he was at one point afraid to make a report to the nurse regarding ULP-I's behavior because ULP-I and the nurse were friends. The case manager indicated that she was aware ULP-I was later terminated due to other, unrelated inappropriate behavior, and that C1's concerns with sexual abuse and ULP-I had been reported to the facility.

The Director of Operations (DO) was interviewed on 1/28/2021 at 11:37 a.m. and indicated she was not aware of any concerns regarding ULP-I and C1 and not aware of any allegations of abuse including C1.

The DON was interviewed on 1/28/2021 at 1:08 pm and stated she was unaware of any complaints or allegations of abuse by C1 involving ULP-I.

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0 805	Continued From page 21 The Executive Director (ED) was also interviewed on 1/28/2021 at and was unaware of any concerns or allegations of abuse involving C1 and ULP-I. In an interview with the ED on 1/29/2021 at 1:52 p.m. she confirmed that any allegations of abuse, negelct or maltreatment should be internally reported and reported to the state agency (SA) and/or police department immediately in accordance with the facility policy. IMPAIRED STAFF MEMBER, ALLEGED SEXUAL CONTACT BETWEEN STAFF AND CLIENTS (C2 and/or C3) A report made to the state agency (SA) on 12/28/2020 included an allegation that a staff member "got drunk" at the facility and was later found sleeping in the medication room. During an onsite complaint investigation on 1/28/2021 the Director of Nursing (DON) was interviewed upon entrance and stated the facility had no grievances or complaints on file from the last three months and no formal vulnerable adult (VA) reports that had been filed in the last three months. An interview with a client (C1) on 1/28/2021 at 11:03 a.m. indicated that he was aware of an incident with a staff member (unlicensed personnel/ULP-I) who was caught in another client's room "drinking and fornicating" and was later fired for this behavior. C1 also reported he was sexually assualted by ULP-I and that ULP-I was inappropriate with other clients. C1 stated he had reported these concerns to staff and management but no follow up had been made regarding his concerns.	0 805		

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0 805	Continued From page 22 The Director of Operations (DO) was interviewed on 1/28/2021 at 11:31 a.m. who stated she was unaware of any formal complaints that C1 had made regarding ULP-I. The DO stated she was unaware of any complaints regarding ULP-I being sexually inappropriate with C1 or any other clients. However, the DO did indicate that ULP-I was sent home from the facility due to appearing intoxicated and was later terminated. The DO stated she was unaware of the details of the termination or incident surrounding the alleged intoxication involving ULP-I. The Director of Nursing (DON) was interviewed on 1/28/2021 at 1:08 p.m. who stated she was called by a staff member (Unlicensed personnel/ULP-C) around 7:00 p.m. on 12/18/2020 who reported ULP-I was intoxicated at the facility. The DON stated she came to the facility and assessed ULP-I, and determined ULP-I was intoxicated. The DON stated she sent ULP-I home. During the interview with the DON, the DON indicated she later found out that ULP-I had been drinking with one of the clients (C2) and that ULP-I was in a relationship with another client (C3). The DON stated she had heard that ULP-I had returned to the faciliy after the DON had sent her home on 12/18/2020 and continued to work a night shift, but that this was a "rumor" and she had not been called by staff later in the evening of 12/18/2020-12/19/2020 so she did not know if ULP-I returned or if she worked again that evening. In addition, the DON stated she attempted to follow up with C2 and C3 regarding the rumors she heard regarding ULP-I but both clients swore at her so she did not continue to look into the allegations. The DON stated she did not file a VA report as she did not view the incident involving ULP-I's drinking and alleged	0 805		

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0 805	Continued From page 23 involvment with C2 and C3 in that way. The DON confirmed she did not follow up into review of whether ULP-I returned to the facility or if she worked the night shift after being sent home. The DON indicated she had completed a statement regarding this incident and ULP-I was terminated after this incident and had not returned to the facility. Review of the DON's statement dated 12/19/2020 indicated the following regarding ULP-I: "Staff called me at home Saturday night around 7pm to report that [ULP-I] is drunk and high at work. I came into work to investigate the situation. [ULP-I] was on 3rd floor. I found her by the elevator. She was slurring her words, her eyes were red and half closed. She could not walk a straight line. I talked with her for about 10 minutes and I made the decision to send her home and I told her to go home. She left in her car. I found out the next day that she came back to work and worked her shift and stayed for the night shift. Staff reported to me that she was sleeping in the medication room on the floor all night. When I asked her to go home Saturday evening, she left with one of our residents in her car. She was driving him around to different places. She was also seen in another truck with one of our other residents. It was reported to me that she was in resident's apartment for quite awhile and [ULP-I] was telling the other charges that she wanted to have sex with male resident. Narcotics are also missing from Narcotic drawer." A second statement was included on the DON's statement which included the following: "On the evening of the 13th of December. Staff also called me to tell me [ULP-I] was in the medication room sleeping and they couldn't get in the medication room because she had the key.	0 805		

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0 805	Continued From page 24 Staff was knocking on the door but she didn't wake up. I then came into work to unlock the medication room and wake [ULP-I] up. She was sleeping sitting up in a chair and was very difficult to wake up. She finally woke up after shaking her, she was confused and disorientated. I waited for her to fully wake up. She was very apologetic and she has been working a lot of doubles. She was coherent and answering my questions correctly. I was going to send her home that day but I gave her a second chance". ULP-I's timecard dated 12/18/2020 - 12/19/2020 was reviewed, which indicated ULP-I was punched in from 2:59 p.m. - 12:00 a.m. on 12/18/2020 and from 12:00 a.m.- 7:25 a.m. on 12/19/2020. ULP-C was interviewed on 1/28/2021 at 2:10 p.m. and confirmed she was the staff member who contacted the DON regarding ULP-I's behavior on 12/18/2020. ULP-C stated she was not working the evening of 12/18/2020 but had came to the facilty to help a client (C2) with a plant as she had promised earlier in the day. ULP-C stated she arrived at the facilty between 5:30 p.m. and 6:30 p.m. and found ULP-I in her car with C2. ULP-C stated ULP-I waved her over to the car and told ULP-C she was drunk; ULP-I stated she had four tequila shots and a beer. ULP-C was concerned about ULP-I's behavior and convinced C2 and ULP-I to come back in to the facilty. ULP-C told C2 she was at the facility to assist him with his plant as promised and had C2 return to his room. ULP-C stated she then called another lead staff member (unlicensed personnel/ULP-H) and the DON regarding ULP-I's behavior and statement regarding drinking. ULP-C stated she remained at the facility until the DON arrived to speak with ULP-I. ULP-C stated after the DON arrived and	0 805		

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0 805	Continued From page 25 spoke with ULP-I, ULP-I left in her car. ULP-C stated she recieved a text message that ULP-I returned later in the shift but did not recall any follow-up, if any, she completed regarding ULP-I returning to the facility. ULP-C completed a statement regarding the 12/18/2020 incident with ULP-I. ULP-C's statement included the following information: ULP-C arrived at the facility and found ULP-I and C2 in ULP-I's car. ULP-I told ULP-C that she was "drunk and had got drunk on the job". ULP-C observed ULP-I "could barely open her eyes". After ULP-C had ULP-I and C2 return to the building, ULP-C observed alcohol and alcohol bottles in C2's room. ULP-C stated C2 was concerned about ULP-I, and that ULP-I wanted to "have sex" with C3; C2 asked ULP-C to go to C3's room to make sure ULP-I was not "making any mistakes." When ULP-C arrived at C3's room, she found ULP-I "flirting and talking to [C3] about her butt." ULP-C's statement indicated she tried to "help" ULP-I but she did not want her there so she left and returned to C2's room. ULP-C's statement indicated she then called ULP-G and the DON to report ULP-C's behavior. ULP-E and ULP-F were interviewed on 1/28/2020 at 3:50 p.m. and confirmed they were also working the evening of 12/18/2020. ULP-E and ULP-F indicated they heard from other staff members that ULP-I was drunk during their shift. ULP-E and ULP-F stated the DON came to speak with ULP-I, and the DON and ULP-I left the facility. ULP-E and ULP-F stated ULP-I later returned to the facility and asked which staff member "snitched" on her. ULP-E and ULP-F stated they witnessed ULP-I later leave the facility with C3, and ULP-I told ULP-E and ULP-F that she was smoking marijuana with C3. ULP-E and	0 805		

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0 805	Continued From page 26	0 805		

ULP-F stated ULP-I stayed to work for the night shift as she was the only lead worker scheduled for the shift. ULP-E and ULP-F stated they told the oncoming night shift staff (ULP-G) about ULP-I's behavior. ULP-G later text ULP-E and ULP-F stating that ULP-I was "out of it" and "kept talking" during the shift and later fell asleep in the medication room.

ULP-H was interviewed on 2/16/2021 at 2:13 p.m. and stated she received a phone call on 12/18/2020 from ULP-C that ULP-I was intoxicated and unable to perform her duties. ULP-H stated ULP-C called her regarding ULP-I's behavior as ULP-I had admitted she became intoxcated during her shift and was not cooperating with ULP-C. ULP-H then directed ULP-C to call the DON and stated she would come to the facility to meet ULP-C, ULP-I and the DON. ULP-H stated she arrived at the facility and the DON spoke with ULP-I and shortly after ULP-I, the DON and ULP-H left the facility. ULP-H stated when ULP-I left the facility a male was in the car with her but she was not sure of who the male was or if it was a client from the facility. ULP-H further stated she later heard that ULP-I returned to the facility and worked the overnight shift and fell asleep in the medication room. ULP-H stated she could not recall who she had heard this from but stated that it should have been reported. ULP-H indicated that the DON was aware of the incident with ULP-I and assumed this incident would be reported, but not aware of any further action taken.

ULP-J was interviewed on 2/4/2021 at 12:23 p.m. and stated she worked the night shift 12/18/2020-12/19/2020. ULP-J confirmed ULP-I worked the night shift. ULP-J stated she was informed by other staff members that ULP-I had

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0 805	Continued From page 27 been drinking with residents and was intoxicated. ULP-J stated ULP-I "definately did seem impaired" and she fell asleep in the medication room. ULP-J stated she thought the DON was aware of ULP-I's behavior as she had heard the DON was at the facility earlier, and ULP-I told her that someone had "snitched" on her and talked about a text message she sent to the DON and administrator. ULP-J stated ULP-I later fell asleep in the medication room towards the end of the shift and staff had to come back twice to try to wake ULP-I up who eventually woke up and opened the door for staff to pass medications. ULP-J stated ULP-I did not pass medications during the overnight shift and was unaware of, if any, services or what work ULP-I completed. ULP-J stated she heard ULP-I no longer worked at the facility following this incident. A follow-up interview was completed with the DON on 1/29/2021 at 1:45 p.m. During the interview the DON again confirmed she was made aware of allegations of ULP-I drinking with clients, leaving with clients in her car after being sent home intoxicated, wanting to have a sexual relationship with a client, and narcotics missing after ULP-I was asleep in the medication room and did not report these allegations as she did not feel that these were reportable incidents. The DON confirmed ULP-I was assigned as the lead staff member on 12/18/2020 and that the DON had assessed ULP-I to be intoxicated and not competent to work on 12/18/2020 and that is why she sent her home. The DON could not provide an answer to why she did not further look into ULP-I's return to the facility or further alleged behavior with clients C2 and C3 on the evening of 12/18-12/19/2020 but stated she should not have been working at the facility after being sent home. The DON stated she felt ULP-I was being taken	0 805		

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0 805	Continued From page 28 advantage of by the clients (C2,C3) and said she did not view the clients as vulnerable adults. The DON stated she had not recieved vulnerable adult reporting training upon hire and not aware this incident would constitute a vulnerable adult report. The DON did indicate she completed a statement regarding this incident and that human resources (HR) should have been aware of what had happened and that she thought she reported the incidents to the DO. The DON was questioned about her continued statement indicating a previous incident on 12/13/2020 where ULP-I was alseep in the medication room. The DON stated she wanted to give ULP-I a second chance and allowed ULP-I to continue to work her shift after falling asleep on 12/13/2020. The DON indicated that ULP-I was the "lead charge" and had been working multiple shifts. The DON confirmed she had not reported this concern at the time but allowed ULP-I to finish her shift with no additional supervision. When asked about what narcotics were missing, the DON could not recall specific narcotics and also stated she was unaware of any reporting requirements regarding missing narcotics and could not provide details on her follow up on the missing narcotics. The facility was asked to provide reports of missing narcotics, however no report regarding missing narcotics was available surrounding the date of 12/13/2021 or regarding missing narcotics while ULP-I was working or passing medications. Review of the DON's personnel file indicated she recieved vulnerable adult (VA) training on 1/20/2021. C2 and C3 both declined to be interviewed.	0 805		

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0 805	Continued From page 29 C2's medical record was reviewed and indicated C2 was admitted to the facility on 9/01/2020 with diagnoses which included schitzoaffective disorder, hypertension, diabetes mellitus type II and substance dependence. C2's vulerability, safety and risk assessment dated 11/24/2020 indicated C2 was alert and oriented to person, place and time and able to provide accurate and consistent information. C3's medical record was reviewed and indicated C3 was admitted to the facility on 9/01/2020 with diagnoses which included bipolar disorder, anxiety, PTSD, and depression. C3's vulerability, safety and risk assessment dated 9/1/2020 indicated C3 was alert and oriented to person, place and time and able to provide accurate and consistent information. C3's vulerability assessment included C3 had a history of marijuana use and identified vulnerabilities due to paranoia, anxiety, bipolar disorder, PTSD and depression. The assessment further indicated C3 was able to accurately report abuse and neglect. ULP-I was terminated from the facility on 12/21/2020 due to a violation of the facility's drug and alcohol policy. ULP-I was unavailable for interview. ULP-I's employee file was reviewed and indicated ULP-I had recieved vulnerable adult training, professional boundaries and ethics training as well as the company's drug and alcohol policy upon hire. A follow-up interview was completed with the DO on 2/17/2021 at 2:18 p.m. who stated she was unaware of the specifics of the incident regarding ULP-I being intoxicated and later termination. The	0 805		

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0 805	Continued From page 30 DO indicated she assumed the DON and HR had handled the situation in accordance with the corporation's policies. The DO indicated she was unaware of the specifics of the incident and indicated the incident should have been filed as a VA report upon the DON learning about ULP-I's alleged actions of drinking with clients, the allegation of having a sexual relationship with a client, and missing narcotics, and an investigation should have been completed. The DO indicated she was unaware of ULP-I asleep in the medication room and missing narcotics, however stated ULP-I should have been disciplined in accordance with corporate procedures and the DON should have followed the appropriate steps to complete this action at the time the incident occurred. The DO further indicated the DON had recieved training regarding VA reporting as had all staff who work at the facility. The DO also indicated she was concerned that ULP-I had returned to the facility after being sent home, that staff did not further report this and allowed ULP-I to remain at the facility. The DO had not reviewed ULP-I's timecard and was unaware that ULP-I worked the night shift after being sent home the on the evening shift. The DO was unaware of the specifics of ULP-I's termination and if anyone had followed up on the specifics on the incident from human resources or corporate office regarding these allegations and based upon what was written in the statements provided from the DON and ULP-C. OTHER INCIDENTS During interviews with other clients on January 28 and 29, 2021, references were made to a a female client who has previously reported being sexually assaulted by another client, and that law enforcement officers were present in response to that incident and to multiple other incidents over	0 805		

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0 805	Continued From page 31 the preceding two months. In addition, multiple clients indicated they had made complaints regarding not receiving all services they were supposed to receive. On February 1, 2021, law enforcement reports were requested for any law enforcement calls to this housing with services. The local law enforcement agency responsed to the state agency and stated there were multiple reports of their calls to this housing with services location served by the licensee. Vulnerable adult (VA) reports dating back the last three months from the onsite date of 1/28/2021 were requested from the facility and none were provided that indicate the facility had self-reported incidents involved a female client possibly having been sexually assaulted, law enforcement responding to the facility, or clients not receiving ordered services; there were no reports filed in the last three months. --- The facility's Vulnerable Adult Reporting and Investigation Policy dated January 2020 included that staff were expected to report any allegations of suspected maltreatment in accordance with state and federal laws and that allegations of maltreatment would be investigated by the RN and Administrator and then consulted with the Director of Operations. The policy indicated all staff would be trained on reporting policies and procedures and upon report of maltreatment an written notice would be provided to the internal reporter of maltreatment on the follow up of the incident and an internal investigation would be conducted of the alleged incident. TIME PERIOD FOR CORRECTION: Seven Days	0 805		

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02015 SS=F	626.557, Subd. 3 Timing of Report 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: (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 (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (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. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section	02015		

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02015	Continued From page 33 626.5572, 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 investigative 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 investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to immediately report maltreatment of vulnerable adults to the common entry point (CEP) when the facility became aware of allegations of maltreatment for 3 of 3 clients (C1, C2, C3) reviewed for maltreatment. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: During an onsite complaint investigation on	02015		

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02015	Continued From page 34 1/28/2021 the Director of Nursing (DON) was interviewed upon entrance and stated the facility had no grievances or complaints on file from the last three months and no formal vulnerable adult (VA) reports that had been filed in the last three months. SEXUAL CONTACT A complaint was made to the state agency (SA) on 12/18/2020 which included an allegation of sexual abuse involving a client (C1) and a staff member who was putting her breasts in C1's face and wheelchair and stating "I can make you love me" three times over the last two weeks, causing C1 to feel uncomfortable and targeted at the facility. The complaint said these concerns were reported to the facility but nothing had been done. C1's medical record indicated C1 was admitted to the facility on 11/04/2020 with diagnoses which included hypertension, chronic pain and depression. C1's vulnerability assessment dated 11/05/2020 indicated C1 was alert and oriented to person, time, place and situation. The vulnerability assessment indicated C1 was not a risk for abuse or harm to others and was able to report abuse by others and identified C1 as able to provide accurate information consistently. The client (C1) was interviewed on 1/28/2021 at 11:03 a.m. and reported he was sexually assualted by ULP-I and that ULP-I was inappropriate with other clients. C1 reported ULP-I had sexually harrassed him; "she would come over and bend over and put her boobs on her shoulder" and say "I'm gonna make you love me". C1 further reported ULP-I was sexually inappropriate with other clients. C1 stated he had reported these concerns to staff and management but no follow up had been made	02015		

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regarding his concerns. C1 indicated he wanted to sue ULP-I for sexual harrassmentand said ULP-I had been fired from the facility due to being "drunk on the job." C1 further stated he did not feel safe at the facility and was looking into placement at a different facility.

Vulnerable adult (VA) reports dating back the last three months from the onsite date of 1/28/2021 were requested from the facility, however none were provided as there were no reports filed in the last three months.

Staff interviews conducted indicated staff had knowledge of C1's report of sexual abuse by ULP-I:

- ULP-D was interviewed on 1/28/2021 at 3:20 p.m. and indicated she was aware that C1 had concerns with ULP-I's behavior. ULP-D stated C1 did not like ULP-I because ULP-I hugged him and he did not like it; ULP-I said she would make C1 like it.

- ULP-E and ULP-F were interviewed on 1/28/2021 at 3:50 p.m. and indicated ULP-I was unprofessional and inappropriate to both staff and residents. ULP-E and ULP-F stated they were afraid to question ULP-I's behavior as she was their supervisor; ULP-I was lead worker during their shifts. ULP-E and ULP-F stated C1 had told them that ULP-I "shook her tits in my face" and stated she was going to "make you love me". ULP-E and ULP-F stated C1 reported to them that he did not like ULP-I, and ULP-I was aware of that and always tried to build a relationship with C1 saying she was going to "make him" like her.

- ULP-H was interviewed on 2/16/2021 at 2:13 p.m. and stated she was aware of C1's concerns

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involving ULP-I. ULP-H stated C1 had told her he was uncomfortable with ULP-I because of her an incident where her breasts rubbed on his shoulder. C1 told ULP-H he was uncomfortable around ULP-I and wanted nothing to do with her and he felt disrespected. ULP-H indicated ULP-I was aware of how C1 felt and that she still continued to try to build a relationship with him and did not respect his wishes. ULP-H indicated that the DON was made aware of C1's concerns regarding ULP-I.

Several attempts were made to contact ULP-I but were not successful.

C1's case manager was interviewed on 1/27/2021 at 2:36 pm and indicated she was aware of C1's concerns related to ULP-I's behavior. The case manager indicated C1 had reported to her that ULP-I was sexually abusing him by pushing herself in his face. C1 reported he was at one point afraid to make a report to the nurse regarding ULP-I's behavior because ULP-I and the nurse were friends. The case manager indicated that she was aware ULP-I was later terminated due to other, unrelated inappropriate behavior, and that C1's concerns with sexual abuse and ULP-I had been reported to the facility.

The Director of Operations (DO) was interviewed on 1/28/2021 at 11:37 a.m. and indicated she was not aware of any concerns regarding ULP-I and C1 and not aware of any allegations of abuse including C1.

The DON was interviewed on 1/28/2021 at 1:08 pm and stated she was unaware of any complaints or allegations of abuse by C1 involving ULP-I.

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The Executive Director (ED) was also interviewed on 1/28/2021 at and was unaware of any concerns or allegations of abuse involving C1 and ULP-I.

In an interview with the ED on 1/29/2021 at 1:52 p.m. she confirmed that any allegations of abuse, negelct or maltreatment should be internally reported and reported to the state agency (SA) and/or police department immediately in accordance with the facility policy.

IMPAIRED STAFF MEMBER, ALLEGED SEXUAL CONTACT BETWEEN STAFF AND CLIENTS (C2 and/or C3)
A report made to the state agency (SA) on 12/28/2020 included an allegation that a staff member "got drunk" at the facility and was later found sleeping in the medication room.

During an onsite complaint investigation on 1/28/2021 the Director of Nursing (DON) was interviewed upon entrance and stated the facility had no grievances or complaints on file from the last three months and no formal vulnerable adult (VA) reports that had been filed in the last three months.

An interview with a client (C1) on 1/28/2021 at 11:03 a.m. indicated that he was aware of an incident with a staff member (unlicensed personnel/ULP-I) who was caught in another client's room "drinking and fornicating" and was later fired for this behavior. C1 also reported he was sexually assualted by ULP-I and that ULP-I was inappropriate with other clients. C1 stated he had reported these concerns to staff and management but no follow up had been made regarding his concerns.

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02015	Continued From page 38 The Director of Operations (DO) was interviewed on 1/28/2021 at 11:31 a.m. who stated she was unaware of any formal complaints that C1 had made regarding ULP-I. The DO stated she was unaware of any complaints regarding ULP-I being sexually inappropriate with C1 or any other clients. However, the DO did indicate that ULP-I was sent home from the facility due to appearing intoxicated and was later terminated. The DO stated she was unaware of the details of the termination or incident surrounding the alleged intoxication involving ULP-I. The Director of Nursing (DON) was interviewed on 1/28/2021 at 1:08 p.m. who stated she was called by a staff member (Unlicensed personnel/ULP-C) around 7:00 p.m. on 12/18/2020 who reported ULP-I was intoxicated at the facility. The DON stated she came to the facility and assessed ULP-I, and determined ULP-I was intoxicated. The DON stated she sent ULP-I home. During the interview with the DON, the DON indicated she later found out that ULP-I had been drinking with one of the clients (C2) and that ULP-I was in a relationship with another client (C3). The DON stated she had heard that ULP-I had returned to the faciliy after the DON had sent her home on 12/18/2020 and continued to work a night shift, but that this was a "rumor" and she had not been called by staff later in the evening of 12/18/2020-12/19/2020 so she did not know if ULP-I returned or if she worked again that evening. In addition, the DON stated she attempted to follow up with C2 and C3 regarding the rumors she heard regarding ULP-I but both clients swore at her so she did not continue to look into the allegations. The DON stated she did not file a VA report as she did not view the incident involving ULP-I's drinking and alleged	02015		

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involvment with C2 and C3 in that way. The DON confirmed she did not follow up into review of whether ULP-I returned to the facility or if she worked the night shift after being sent home. The DON indicated she had completed a statement regarding this incident and ULP-I was terminated after this incident and had not returned to the facility.

Review of the DON's statement dated 12/19/2020 indicated the following regarding ULP-I:
"Staff called me at home Saturday night around 7pm to report that [ULP-I] is drunk and high at work. I came into work to investigate the situation. [ULP-I] was on 3rd floor. I found her by the elevator. She was slurring her words, her eyes were red and half closed. She could not walk a straight line. I talked with her for about 10 minutes and I made the decision to send her home and I told her to go home. She left in her car. I found out the next day that she came back to work and worked her shift and stayed for the night shift. Staff reported to me that she was sleeping in the medication room on the floor all night. When I asked her to go home Saturday evening, she left with one of our residents in her car. She was driving him around to different places. She was also seen in another truck with one of our other residents. It was reported to me that she was in resident's apartment for quite awhile and [ULP-I] was telling the other charges that she wanted to have sex with male resident. Narcotics are also missing from Narcotic drawer."

A second statement was included on the DON's statement which included the following:
"On the evening of the 13th of December. Staff also called me to tell me [ULP-I] was in the medication room sleeping and they couldn't get in the medication room because she had the key.

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Staff was knocking on the door but she didn't wake up. I then came into work to unlock the medication room and wake [ULP-I] up. She was sleeping sitting up in a chair and was very difficult to wake up. She finally woke up after shaking her, she was confused and disorientated. I waited for her to fully wake up. She was very apologetic and she has been working a lot of doubles. She was coherent and answering my questions correctly. I was going to send her home that day but I gave her a second chance".

ULP-I's timecard dated 12/18/2020 - 12/19/2020 was reviewed, which indicated ULP-I was punched in from 2:59 p.m. - 12:00 a.m. on 12/18/2020 and from 12:00 a.m.- 7:25 a.m. on 12/19/2020.

ULP-C was interviewed on 1/28/2021 at 2:10 p.m. and confirmed she was the staff member who contacted the DON regarding ULP-I's behavior on 12/18/2020. ULP-C stated she was not working the evening of 12/18/2020 but had came to the facilty to help a client (C2) with a plant as she had promised earlier in the day. ULP-C stated she arrived at the facilty between 5:30 p.m. and 6:30 p.m. and found ULP-I in her car with C2. ULP-C stated ULP-I waved her over to the car and told ULP-C she was drunk; ULP-I stated she had four tequila shots and a beer. ULP-C was concerned about ULP-I's behavior and convinced C2 and ULP-I to come back in to the facilty. ULP-C told C2 she was at the facility to assist him with his plant as promised and had C2 return to his room. ULP-C stated she then called another lead staff member (unlicensed personnel/ULP-H) and the DON regarding ULP-I's behavior and statement regarding drinking. ULP-C stated she remained at the facility until the DON arrived to speak with ULP-I. ULP-C stated after the DON arrived and

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spoke with ULP-I, ULP-I left in her car. ULP-C stated she recieved a text message that ULP-I returned later in the shift but did not recall any follow-up, if any, she completed regarding ULP-I returning to the facility.

ULP-C completed a statement regarding the 12/18/2020 incident with ULP-I. ULP-C's statement included the following information: ULP-C arrived at the facility and found ULP-I and C2 in ULP-I's car. ULP-I told ULP-C that she was "drunk and had got drunk on the job". ULP-C observed ULP-I "could barely open her eyes". After ULP-C had ULP-I and C2 return to the building, ULP-C observed alcohol and alcohol bottles in C2's room. ULP-C stated C2 was concerned about ULP-I, and that ULP-I wanted to "have sex" with C3; C2 asked ULP-C to go to C3's room to make sure ULP-I was not "making any mistakes." When ULP-C arrived at C3's room, she found ULP-I "flirting and talking to [C3] about her butt." ULP-C's statement indicated she tried to "help" ULP-I but she did not want her there so she left and returned to C2's room. ULP-C's statement indicated she then called ULP-G and the DON to report ULP-C's behavior.

ULP-E and ULP-F were interviewed on 1/28/2020 at 3:50 p.m. and confirmed they were also working the evening of 12/18/2020. ULP-E and ULP-F indicated they heard from other staff members that ULP-I was drunk during their shift. ULP-E and ULP-F stated the DON came to speak with ULP-I, and the DON and ULP-I left the facility. ULP-E and ULP-F stated ULP-I later returned to the facility and asked which staff member "snitched" on her. ULP-E and ULP-F stated they witnessed ULP-I later leave the facility with C3, and ULP-I told ULP-E and ULP-F that she was smoking marijuana with C3. ULP-E and

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ULP-F stated ULP-I stayed to work for the night shift as she was the only lead worker scheduled for the shift. ULP-E and ULP-F stated they told the oncoming night shift staff (ULP-G) about ULP-I's behavior. ULP-G later text ULP-E and ULP-F stating that ULP-I was "out of it" and "kept talking" during the shift and later fell asleep in the medication room.

ULP-H was interviewed on 2/16/2021 at 2:13 p.m. and stated she received a phone call on 12/18/2020 from ULP-C that ULP-I was intoxicated and unable to perform her duties. ULP-H stated ULP-C called her regarding ULP-I's behavior as ULP-I had admitted she became intoxcated during her shift and was not cooperating with ULP-C. ULP-H then directed ULP-C to call the DON and stated she would come to the facility to meet ULP-C, ULP-I and the DON. ULP-H stated she arrived at the facility and the DON spoke with ULP-I and shortly after ULP-I, the DON and ULP-H left the facility. ULP-H stated when ULP-I left the facility a male was in the car with her but she was not sure of who the male was or if it was a client from the facility. ULP-H further stated she later heard that ULP-I returned to the facility and worked the overnight shift and fell asleep in the medication room. ULP-H stated she could not recall who she had heard this from but stated that it should have been reported. ULP-H indicated that the DON was aware of the incident with ULP-I and assumed this incident would be reported, but not aware of any further action taken.

ULP-J was interviewed on 2/4/2021 at 12:23 p.m. and stated she worked the night shift 12/18/2020-12/19/2020. ULP-J confirmed ULP-I worked the night shift. ULP-J stated she was informed by other staff members that ULP-I had

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been drinking with residents and was intoxicated. ULP-J stated ULP-I "definately did seem impaired" and she fell asleep in the medication room. ULP-J stated she thought the DON was aware of ULP-I's behavior as she had heard the DON was at the facility earlier, and ULP-I told her that someone had "snitched" on her and talked about a text message she sent to the DON and administrator. ULP-J stated ULP-I later fell asleep in the medication room towards the end of the shift and staff had to come back twice to try to wake ULP-I up who eventually woke up and opened the door for staff to pass medications. ULP-J stated ULP-I did not pass medications during the overnight shift and was unaware of, if any, services or what work ULP-I completed. ULP-J stated she heard ULP-I no longer worked at the facility following this incident.

A follow-up interview was completed with the DON on 1/29/2021 at 1:45 p.m. During the interview the DON again confirmed she was made aware of allegations of ULP-I drinking with clients, leaving with clients in her car after being sent home intoxicated, wanting to have a sexual relationship with a client, and narcotics missing after ULP-I was asleep in the medication room and did not report these allegations as she did not feel that these were reportable incidents. The DON confirmed ULP-I was assigned as the lead staff member on 12/18/2020 and that the DON had assessed ULP-I to be intoxicated and not competent to work on 12/18/2020 and that is why she sent her home. The DON could not provide an answer to why she did not further look into ULP-I's return to the facility or further alleged behavior with clients C2 and C3 on the evening of 12/18-12/19/2020 but stated she should not have been working at the facility after being sent home. The DON stated she felt ULP-I was being taken

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02015	Continued From page 44 advantage of by the clients (C2,C3) and said she did not view the clients as vulnerable adults. The DON stated she had not recieved vulnerable adult reporting training upon hire and not aware this incident would constitute a vulnerable adult report. The DON did indicate she completed a statement regarding this incident and that human resources (HR) should have been aware of what had happened and that she thought she reported the incidents to the DO. The DON was questioned about her continued statement indicating a previous incident on 12/13/2020 where ULP-I was alseep in the medication room. The DON stated she wanted to give ULP-I a second chance and allowed ULP-I to continue to work her shift after falling asleep on 12/13/2020. The DON indicated that ULP-I was the "lead charge" and had been working multiple shifts. The DON confirmed she had not reported this concern at the time but allowed ULP-I to finish her shift with no additional supervision. When asked about what narcotics were missing, the DON could not recall specific narcotics and also stated she was unaware of any reporting requirements regarding missing narcotics and could not provide details on her follow up on the missing narcotics. The facility was asked to provide reports of missing narcotics, however no report regarding missing narcotics was available surrounding the date of 12/13/2021 or regarding missing narcotics while ULP-I was working or passing medications. Review of the DON's personnel file indicated she recieved vulnerable adult (VA) training on 1/20/2021. C2 and C3 both declined to be interviewed.	02015		

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C2's medical record was reviewed and indicated C2 was admitted to the facility on 9/01/2020 with diagnoses which included schitzoaffective disorder, hypertension, diabetes mellitus type II and substance dependence. C2's vulerability, safety and risk assessment dated 11/24/2020 indicated C2 was alert and oriented to person, place and time and able to provide accurate and consistent information.

C3's medical record was reviewed and indicated C3 was admitted to the facility on 9/01/2020 with diagnoses which included bipolar disorder, anxiety, PTSD, and depression. C3's vulerability, safety and risk assessment dated 9/1/2020 indicated C3 was alert and oriented to person, place and time and able to provide accurate and consistent information. C3's vulerability assessment included C3 had a history of marijuana use and identified vulnerabilities due to paranoia, anxiety, bipolar disorder, PTSD and depression. The assessment further indicated C3 was able to accurately report abuse and neglect.

ULP-I was terminated from the facility on 12/21/2020 due to a violation of the facility's drug and alcohol policy.

ULP-I was unavailable for interview.

ULP-I's employee file was reviewed and indicated ULP-I had recieved vulnerable adult training, professional boundaries and ethics training as well as the company's drug and alcohol policy upon hire.

A follow-up interview was completed with the DO on 2/17/2021 at 2:18 p.m. who stated she was unaware of the specifics of the incident regarding ULP-I being intoxicated and later termination. The

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DO indicated she assumed the DON and HR had handled the situation in accordance with the corporation's policies. The DO indicated she was unaware of the specifics of the incident and indicated the incident should have been filed as a VA report upon the DON learning about ULP-I's alleged actions of drinking with clients, the allegation of having a sexual relationship with a client, and missing narcotics, and an investigation should have been completed. The DO indicated she was unaware of ULP-I asleep in the medication room and missing narcotics, however stated ULP-I should have been disciplined in accordance with corporate procedures and the DON should have followed the appropriate steps to complete this action at the time the incident occurred. The DO further indicated the DON had recieved training regarding VA reporting as had all staff who work at the facility. The DO also indicated she was concerned that ULP-I had returned to the facility after being sent home, that staff did not further report this and allowed ULP-I to remain at the facility. The DO had not reviewed ULP-I's timecard and was unaware that ULP-I worked the night shift after being sent home the on the evening shift. The DO was unaware of the specifics of ULP-I's termination and if anyone had followed up on the specifics on the incident from human resources or corporate office regarding these allegations and based upon what was written in the statements provided from the DON and ULP-C.

OTHER INCIDENTS
During interviews with other clients on January 28 and 29, 2021, references were made to a a female client who has previously reported being sexually assaulted by another client, and that law enforcement officers were present in response to that incident and to multiple other incidents over

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the preceding two months. In addition, multiple clients indicated they had made complaints regarding not receiving all services they were supposed to receive.

On February 1, 2021, law enforcement reports were requested for any law enforcement calls to this housing with services. The local law enforcement agency responsed to the state agency and stated there were multiple reports of their calls to this housing with services location served by the licensee.

Vulnerable adult (VA) reports dating back the last three months from the onsite date of 1/28/2021 were requested from the facility and none were provided that indicate the facility had self-reported incidents involved a female client possibly having been sexually assaulted, law enforcement responding to the facility, or clients not receiving ordered services; there were no reports filed in the last three months.

The facility's Vulnerable Adult Reporting and Investigation Policy dated January 2020 included that staff were expected to report any allegations of suspected maltreatment in accordance with state and federal laws and that allegations of maltreatment would be investigated by the RN and Administrator and then consulted with the Director of Operations. The policy indicated all staff would be trained on reporting policies and procedures and upon report of maltreatment an written notice would be provided to the internal reporter of maltreatment on the follow up of the incident and an internal investigation would be conducted of the alleged incident.

TIME PERIOD FOR CORRECTION: Seven Days

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02030 SS=F	626.557, Subd. 4a Internal Reporting of Maltreatment Subd. 4a.Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. (b) A facility with an internal reporting procedure that receives an internal report by a mandated reporter shall give the mandated reporter a written notice stating whether the facility has reported the incident to the common entry point. The written notice must be provided within two working days and in a manner that protects the confidentiality of the reporter. (c) The written response to the mandated reporter shall note that if the mandated reporter is not satisfied with the action taken by the facility on whether to report the incident to the common entry point, then the mandated reporter may report externally. (d) A facility may not prohibit a mandated reporter from reporting externally, and a facility is prohibited from retaliating against a mandated reporter who reports an incident to the common entry point in good faith. The written notice by the facility must inform the mandated reporter of this protection from retaliatory measures by the facility against the mandated reporter for reporting externally.	02030		

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02030	Continued From page 49 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to internally report allegations of maltreatment and failed to follow the facility's written procedure regarding reporting of maltreatment for 3 of 3 clients (C1, C2, C3) reviewed for maltreatment. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: Findings include: During an onsite complaint investigation on 1/28/2021 the Director of Nursing (DON) was interviewed upon entrance and stated the facility had no grievances or complaints on file from the last three months and no formal vulnerable adult (VA) reports that had been filed in the last three months. SEXUAL CONTACT A complaint was made to the state agency (SA) on 12/18/2020 which included an allegation of sexual abuse involving a client (C1) and a staff member who was putting her breasts in C1's face and wheelchair and stating "I can make you love me" three times over the last two weeks, causing C1 to feel uncomfortable and targeted at the	02030		

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facility. The complaint said these concerns were reported to the facility but nothing had been done.

C1's medical record indicated C1 was admitted to the facility on 11/04/2020 with diagnoses which included hypertension, chronic pain and depression. C1's vulnerability assessment dated 11/05/2020 indicated C1 was alert and oriented to person, time, place and situation. The vulnerability assessment indicated C1 was not a risk for abuse or harm to others and was able to report abuse by others and identified C1 as able to provide accurate information consistently.

The client (C1) was interviewed on 1/28/2021 at 11:03 a.m. and reported he was sexually assualted by ULP-I and that ULP-I was inappropriate with other clients. C1 reported ULP-I had sexually harrassed him; "she would come over and bend over and put her boobs on her shoulder" and say "I'm gonna make you love me". C1 further reported ULP-I was sexually inappropriate with other clients. C1 stated he had reported these concerns to staff and management but no follow up had been made regarding his concerns. C1 indicated he wanted to sue ULP-I for sexual harrassmentand said ULP-I had been fired from the facility due to being "drunk on the job." C1 further stated he did not feel safe at the facility and was looking into placement at a different facility.

Vulnerable adult (VA) reports dating back the last three months from the onsite date of 1/28/2021 were requested from the facility, however none were provided as there were no reports filed in the last three months.

Staff interviews conducted indicated staff had knowledge of C1's report of sexual abuse by

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ULP-I:

- ULP-D was interviewed on 1/28/2021 at 3:20 p.m. and indicated she was aware that C1 had concerns with ULP-I's behavior. ULP-D stated C1 did not like ULP-I because ULP-I hugged him and he did not like it; ULP-I said she would make C1 like it.

- ULP-E and ULP-F were interviewed on 1/28/2021 at 3:50 p.m. and indicated ULP-I was unprofessional and inappropriate to both staff and residents. ULP-E and ULP-F stated they were afraid to question ULP-I's behavior as she was their supervisor; ULP-I was lead worker during their shifts. ULP-E and ULP-F stated C1 had told them that ULP-I "shook her tits in my face" and stated she was going to "make you love me". ULP-E and ULP-F stated C1 reported to them that he did not like ULP-I, and ULP-I was aware of that and always tried to build a relationship with C1 saying she was going to "make him" like her.

- ULP-H was interviewed on 2/16/2021 at 2:13 p.m. and stated she was aware of C1's concerns involving ULP-I. ULP-H stated C1 had told her he was uncomfortable with ULP-I because of her an incident where her breasts rubbed on his shoulder. C1 told ULP-H he was uncomfortable around ULP-I and wanted nothing to do with her and he felt disrespected. ULP-H indicated ULP-I was aware of how C1 felt and that she still continued to try to build a relationship with him and did not respect his wishes. ULP-H indicated that the DON was made aware of C1's concerns regarding ULP-I.

C1's case manager was interviewed on 1/27/2021 at 2:36 pm and indicated she was aware of C1's concerns related to ULP-I's behavior. The case

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manager indicated C1 had reported to her that ULP-I was sexually abusing him by pushing herself in his face. C1 reported he was at one point afraid to make a report to the nurse regarding ULP-I's behavior because ULP-I and the nurse were friends. The case manager indicated that she was aware ULP-I was later terminated due to other, unrelated inappropriate behavior, and that C1's concerns with sexual abuse and ULP-I had been reported to the facility.

The Director of Operations (DO) was interviewed on 1/28/2021 at 11:37 a.m. and indicated she was not aware of any concerns regarding ULP-I and C1 and not aware of any allegations of abuse including C1.

The DON was interviewed on 1/28/2021 at 1:08 pm and stated she was unaware of any complaints or allegations of abuse by C1 involving ULP-I.

The Executive Director (ED) was also interviewed on 1/28/2021 at and was unaware of any concerns or allegations of abuse involving C1 and ULP-I.

IMPAIRED STAFF MEMBER, ALLEGED SEXUAL CONTACT BETWEEN STAFF AND CLIENTS (C2 and/or C3)
A report made to the state agency (SA) on 12/28/2020 included an allegation that a staff member "got drunk" at the facility and was later found sleeping in the medication room.

During an onsite complaint investigation on 1/28/2021 the Director of Nursing (DON) was interviewed upon entrance and stated the facility had no grievances or complaints on file from the

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last three months and no formal vulnerable adult (VA) reports that had been filed in the last three months.

An interview with a client (C1) on 1/28/2021 at 11:03 a.m. indicated that he was aware of an incident with a staff member (unlicensed personnel/ULP-I) who was caught in another client's room "drinking and fornicating" and was later fired for this behavior. C1 also reported he was sexually assualted by ULP-I and that ULP-I was inappropriate with other clients. C1 stated he had reported these concerns to staff and management but no follow up had been made regarding his concerns.

The Director of Operations (DO) was interviewed on 1/28/2021 at 11:31 a.m. who stated she was unaware of any formal complaints that C1 had made regarding ULP-I. The DO stated she was unaware of any complaints regarding ULP-I being sexually inappropriate with C1 or any other clients. However, the DO did indicate that ULP-I was sent home from the facility due to appearing intoxicated and was later terminated. The DO stated she was unaware of the details of the termination or incident surrounding the alleged intoxication involving ULP-I.

The Director of Nursing (DON) was interviewed on 1/28/2021 at 1:08 p.m. who stated she was called by a staff member (Unlicensed personnel/ULP-C) around 7:00 p.m. on 12/18/2020 who reported ULP-I was intoxicated at the facility. The DON stated she came to the facility and assessed ULP-I, and determined ULP-I was intoxicated. The DON stated she sent ULP-I home. During the interview with the DON, the DON indicated she later found out that ULP-I had been drinking with one of the clients (C2) and

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that ULP-I was in a relationship with another client (C3). The DON stated she had heard that ULP-I had returned to the faciliy after the DON had sent her home on 12/18/2020 and continued to work a night shift, but that this was a "rumor" and she had not been called by staff later in the evening of 12/18/2020-12/19/2020 so she did not know if ULP-I returned or if she worked again that evening. In addition, the DON stated she attempted to follow up with C2 and C3 regarding the rumors she heard regarding ULP-I but both clients swore at her so she did not continue to look into the allegations. The DON stated she did not file a VA report as she did not view the incident involving ULP-I's drinking and alleged involvment with C2 and C3 in that way. The DON confirmed she did not follow up into review of whether ULP-I returned to the facility or if she worked the night shift after being sent home. The DON indicated she had completed a statement regarding this incident and ULP-I was terminated after this incident and had not returned to the facility.

Review of the DON's statement dated 12/19/2020 indicated the following regarding ULP-I:
"Staff called me at home Saturday night around 7pm to report that [ULP-I] is drunk and high at work. I came into work to investigate the situation. [ULP-I] was on 3rd floor. I found her by the elevator. She was slurring her words, her eyes were red and half closed. She could not walk a straight line. I talked with her for about 10 minutes and I made the decision to send her home and I told her to go home. She left in her car. I found out the next day that she came back to work and worked her shift and stayed for the night shift. Staff reported to me that she was sleeping in the medication room on the floor all night. When I asked her to go home Saturday

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evening, she left with one of our residents in her car. She was driving him around to different places. She was also seen in another truck with one of our other residents. It was reported to me that she was in resident's apartment for quite awhile and [ULP-I] was telling the other charges that she wanted to have sex with male resident. Narcotics are also missing from Narcotic drawer."

A second statement was included on the DON's statement which included the following:
"On the evening of the 13th of December. Staff also called me to tell me [ULP-I] was in the medication room sleeping and they couldn't get in the medication room because she had the key. Staff was knocking on the door but she didn't wake up. I then came into work to unlock the medication room and wake [ULP-I] up. She was sleeping sitting up in a chair and was very difficult to wake up. She finally woke up after shaking her, she was confused and disorientated. I waited for her to fully wake up. She was very apologetic and she has been working a lot of doubles. She was coherent and answering my questions correctly. I was going to send her home that day but I gave her a second chance".

ULP-I's timecard dated 12/18/2020 - 12/19/2020 was reviewed, which indicated ULP-I was punched in from 2:59 p.m. - 12:00 a.m. on 12/18/2020 and from 12:00 a.m.- 7:25 a.m. on 12/19/2020.

ULP-C was interviewed on 1/28/2021 at 2:10 p.m. and confirmed she was the staff member who contacted the DON regarding ULP-I's behavior on 12/18/2020. ULP-C stated she was not working the evening of 12/18/2020 but had came to the facilty to help a client (C2) with a plant as she had promised earlier in the day. ULP-C stated she

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02030	Continued From page 56 arrived at the facilty between 5:30 p.m. and 6:30 p.m. and found ULP-I in her car with C2. ULP-C stated ULP-I waved her over to the car and told ULP-C she was drunk; ULP-I stated she had four tequila shots and a beer. ULP-C was concerned about ULP-I's behavior and convinced C2 and ULP-I to come back in to the facilty. ULP-C told C2 she was at the facility to assist him with his plant as promised and had C2 return to his room. ULP-C stated she then called another lead staff member (unlicensed personnel/ULP-H) and the DON regarding ULP-I's behavior and statement regarding drinking. ULP-C stated she remained at the facility until the DON arrived to speak with ULP-I. ULP-C stated after the DON arrived and spoke with ULP-I, ULP-I left in her car. ULP-C stated she recieved a text message that ULP-I returned later in the shift but did not recall any follow-up, if any, she completed regarding ULP-I returning to the facility. ULP-C completed a statement regarding the 12/18/2020 incident with ULP-I. ULP-C's statement included the following information: ULP-C arrived at the facility and found ULP-I and C2 in ULP-I's car. ULP-I told ULP-C that she was "drunk and had got drunk on the job". ULP-C observed ULP-I "could barely open her eyes". After ULP-C had ULP-I and C2 return to the building, ULP-C observed alcohol and alcohol bottles in C2's room. ULP-C stated C2 was concerned about ULP-I, and that ULP-I wanted to "have sex" with C3; C2 asked ULP-C to go to C3's room to make sure ULP-I was not "making any mistakes." When ULP-C arrived at C3's room, she found ULP-I "flirting and talking to [C3] about her butt." ULP-C's statement indicated she tried to "help" ULP-I but she did not want her there so she left and returned to C2's room. ULP-C's statement indicated she then called	02030		

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02030	Continued From page 57 ULP-G and the DON to report ULP-C's behavior. ULP-E and ULP-F were interviewed on 1/28/2020 at 3:50 p.m. and confirmed they were also working the evening of 12/18/2020. ULP-E and ULP-F indicated they heard from other staff members that ULP-I was drunk during their shift. ULP-E and ULP-F stated the DON came to speak with ULP-I, and the DON and ULP-I left the facility. ULP-E and ULP-F stated ULP-I later returned to the facility and asked which staff member "snitched" on her. ULP-E and ULP-F stated they witnessed ULP-I later leave the facility with C3, and ULP-I told ULP-E and ULP-F that she was smoking marijuana with C3. ULP-E and ULP-F stated ULP-I stayed to work for the night shift as she was the only lead worker scheduled for the shift. ULP-E and ULP-F stated they told the oncoming night shift staff (ULP-G) about ULP-I's behavior. ULP-G later text ULP-E and ULP-F stating that ULP-I was "out of it" and "kept talking" during the shift and later fell asleep in the medication room. ULP-H was interviewed on 2/16/2021 at 2:13 p.m. and stated she received a phone call on 12/18/2020 from ULP-C that ULP-I was intoxicated and unable to perform her duties. ULP-H stated ULP-C called her regarding ULP-I's behavior as ULP-I had admitted she became intoxcated during her shift and was not cooperating with ULP-C. ULP-H then directed ULP-C to call the DON and stated she would come to the facility to meet ULP-C, ULP-I and the DON. ULP-H stated she arrived at the facility and the DON spoke with ULP-I and shortly after ULP-I, the DON and ULP-H left the facility. ULP-H stated when ULP-I left the facility a male was in the car with her but she was not sure of who the male was or if it was a client from the	02030		

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(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
02030	Continued From page 58 facility. ULP-H further stated she later heard that ULP-I returned to the facility and worked the overnight shift and fell asleep in the medication room. ULP-H stated she could not recall who she had heard this from but stated that it should have been reported. ULP-H indicated that the DON was aware of the incident with ULP-I and assumed this incident would be reported, but not aware of any further action taken. ULP-J was interviewed on 2/4/2021 at 12:23 p.m. and stated she worked the night shift 12/18/2020-12/19/2020. ULP-J confirmed ULP-I worked the night shift. ULP-J stated she was informed by other staff members that ULP-I had been drinking with residents and was intoxicated. ULP-J stated ULP-I "definately did seem impaired" and she fell asleep in the medication room. ULP-J stated she thought the DON was aware of ULP-I's behavior as she had heard the DON was at the facility earlier, and ULP-I told her that someone had "snitched" on her and talked about a text message she sent to the DON and administrator. ULP-J stated ULP-I later fell asleep in the medication room towards the end of the shift and staff had to come back twice to try to wake ULP-I up who eventually woke up and opened the door for staff to pass medications. ULP-J stated ULP-I did not pass medications during the overnight shift and was unaware of, if any, services or what work ULP-I completed. ULP-J stated she heard ULP-I no longer worked at the facility following this incident. A follow-up interview was completed with the DON on 1/29/2021 at 1:45 p.m. During the interview the DON again confirmed she was made aware of allegations of ULP-I drinking with clients, leaving with clients in her car after being sent home intoxicated, wanting to have a sexual	02030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28733	A. BUILDING: ______ B. WING ______	C 01/29/2021

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02030	Continued From page 59 relationship with a client, and narcotics missing after ULP-I was asleep in the medication room and did not report these allegations as she did not feel that these were reportable incidents. The DON confirmed ULP-I was assigned as the lead staff member on 12/18/2020 and that the DON had assessed ULP-I to be intoxicated and not competent to work on 12/18/2020 and that is why she sent her home. The DON could not provide an answer to why she did not further look into ULP-I's return to the facility or further alleged behavior with clients C2 and C3 on the evening of 12/18-12/19/2020 but stated she should not have been working at the facility after being sent home. The DON stated she felt ULP-I was being taken advantage of by the clients (C2,C3) and said she did not view the clients as vulnerable adults. The DON stated she had not recieved vulnerable adult reporting training upon hire and not aware this incident would constitute a vulnerable adult report. The DON did indicate she completed a statement regarding this incident and that human resources (HR) should have been aware of what had happened and that she thought she reported the incidents to the DO. The DON was questioned about her continued statement indicating a previous incident on 12/13/2020 where ULP-I was alseep in the medication room. The DON stated she wanted to give ULP-I a second chance and allowed ULP-I to continue to work her shift after falling asleep on 12/13/2020. The DON indicated that ULP-I was the "lead charge" and had been working multiple shifts. The DON confirmed she had not reported this concern at the time but allowed ULP-I to finish her shift with no additional supervision. When asked about what narcotics were missing, the DON could not recall specific narcotics and also stated she was unaware of any reporting requirements regarding missing narcotics and	02030		

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02030	Continued From page 60	02030		

could not provide details on her follow up on the missing narcotics.

The facility was asked to provide reports of missing narcotics, however no report regarding missing narcotics was available surrounding the date of 12/13/2021 or regarding missing narcotics while ULP-I was working or passing medications.

Review of the DON's personnel file indicated she recieved vulnerable adult (VA) training on 1/20/2021.

C2 and C3 both declined to be interviewed.

C2's medical record was reviewed and indicated C2 was admitted to the facility on 9/01/2020 with diagnoses which included schitzoaffective disorder, hypertension, diabetes mellitus type II and substance dependence. C2's vulerability, safety and risk assessment dated 11/24/2020 indicated C2 was alert and oriented to person, place and time and able to provide accurate and consistent information.

C3's medical record was reviewed and indicated C3 was admitted to the facility on 9/01/2020 with diagnoses which included bipolar disorder, anxiety, PTSD, and depression. C3's vulerability, safety and risk assessment dated 9/1/2020 indicated C3 was alert and oriented to person, place and time and able to provide accurate and consistent information. C3's vulerability assessment included C3 had a history of marijuana use and identified vulnerabilities due to paranoia, anxiety, bipolar disorder, PTSD and depression. The assessment further indicated C3 was able to accurately report abuse and neglect.

ULP-I's employee file was reviewed and indicated

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02030	Continued From page 61 ULP-I had recieved vulnerable adult training, professional boundaries and ethics training as well as the company's drug and alcohol policy upon hire. A follow-up interview was completed with the DO on 2/17/2021 at 2:18 p.m. who stated she was unaware of the specifics of the incident regarding ULP-I being intoxicated and later termination. The DO indicated she assumed the DON and HR had handled the situation in accordance with the corporation's policies. The DO indicated she was unaware of the specifics of the incident and indicated the incident should have been filed as a VA report upon the DON learning about ULP-I's alleged actions of drinking with clients, the allegation of having a sexual relationship with a client, and missing narcotics, and an investigation should have been completed. The DO indicated she was unaware of ULP-I asleep in the medication room and missing narcotics, however stated ULP-I should have been disciplined in accordance with corporate procedures and the DON should have followed the appropriate steps to complete this action at the time the incident occurred. The DO further indicated the DON had recieved training regarding VA reporting as had all staff who work at the facility. The DO also indicated she was concerned that ULP-I had returned to the facility after being sent home, that staff did not further report this and allowed ULP-I to remain at the facility. The DO had not reviewed ULP-I's timecard and was unaware that ULP-I worked the night shift after being sent home the on the evening shift. The DO was unaware of the specifics of ULP-I's termination and if anyone had followed up on the specifics on the incident from human resources or corporate office regarding these allegations and based upon what was written in the statements provided	02030		

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02030	Continued From page 62	02030		

from the DON and ULP-C.

In an interview with the ED on 1/29/2021 at 1:52 p.m. she confirmed that any allegations of abuse, neglect or maltreatment should be internally reported and reported to the state agency (SA) and/or police department immediately in accordance with the facility policy.

The facility's Vulnerable Adult Reporting and Investigation Policy dated January 2020 included that staff were expected to report any allegations of suspected maltreatment in accordance with state and federal laws and that allegations of maltreatment would be investigated by the RN and Administrator and then consulted with the Director of Operations. The policy indicated all staff would be trained on reporting policies and procedures and upon report of maltreatment an written notice would be provided to the internal reporter of maltreatment on the follow up of the incident and an internal investigation would be conducted of the alleged incident.

TIME PERIOD FOR CORRECTION: Seven Days