Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL370511020M
Compliance #: HL370511208C

Date Concluded: September 28, 2022

Name, Address, and County of Licensee Investigated:
Amerigrace Home Care Llc
890 Clarence Street
Saint Paul, MN 55106
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Willette Shafer, RN
Special Investigator
Kris Detsch, RN
Special Investigator

Finding: Not Substantiated

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) abused the resident when the AP forced the resident to have sexual intercourse.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The resident completed a sexual assault examination, and no evidence of a sexual assault was found. Law enforcement did not file charges against the AP and the case was closed. During an interview, the resident said the sexual assault never happened.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigation included review of resident's record including hospital

record, employee files, facility incident report, police reports, internal investigation, and facility policies. The investigator toured the facility and observed interactions between resident and facility staff.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder, bipolar disorder, borderline personally disorder, traumatic stress disorder, and traumatic brain injury. The resident's service plan included assistance with behavior management and medication management. The resident's individual abuse prevention plan indicated the resident was at risk for abusing others by physical aggression, striking out, hitting, kicking, yelling, and screaming. The resident's assessment indicated the resident had paranoia and was suspicious of others.

During an interview, a management staff member said the resident reported during a primary care visit, she was sexually assaulted by a caregiver at the facility. The management staff member said the resident never reported any rape allegations. The management staff said she talked with the resident upon return to the facility and the resident told her the AP raped her every night. The management staff member said the resident talked about her daughter during their conversation, but the resident did not have children.

According to the resident's hospital record, the resident went to the emergency department after the resident reported feeling suicidal. The hospital record indicated the details about the sexual assault allegation were inconsistent and unclear. The hospital completed a sexual assault assessment and found no evidence of a sexual assault. While in the emergency department, the resident reported the sexual assault happened a few weeks ago and later reported the sexual assault happened a few days ago. The resident reported she was sexually assaulted five or six times by the AP.

According to the law enforcement report, the resident reported the AP raped her every night and it started a year or two ago. The law enforcement report indicated the AP denied touching the resident sexually or inappropriately. The law enforcement report indicated the case was closed because of insufficient evidence.

During an interview, the resident denied the AP sexually assaulted her. The resident said, "I lied" when asked about the sexual assault allegation.

During an interview, the AP said, "I didn't touch her". The AP denied sexually assaulting the resident. The AP said there were no charges filed against him by the police.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2
"Abuse" means:
(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.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Not Applicable.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility ensured their surveillance system was always recording. The facility updated the resident's care plan and provided education to staff members.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html
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:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37051	A. BUILDING: _____ B. WING _____	C 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERIGRACE HOME CARE LLC	890 CLARENCE STREET SAINT PAUL, MN 55106

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint 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: #HL370511208C/#HL370511020M On July 28, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were three clients receiving services under the provider's Assisted Living license. The following correction order is issued for #HL370511208C/#HL370511020M, tag identification 0510.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program	0 510		

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0 510	Continued From page 1 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observations, interviews, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to COVID-19. The licensee also failed to ensure one staff member wore appropriate personal protective equipment (PPE) while in resident care areas. The licensee failed to ensure staff completed screening for COVID-19 symptoms upon reporting to work. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 the clients). The findings include: Personal Protective Equipment	0 510		

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0 510	Continued From page 2 The Minnesota Department of Health COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings dated June 30, 2021, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative residents to wear a medical grade well-fitting facemask and eye protection. In addition, it instructed HCW with no face-to-face contact with residents to wear a medical-grade well-fitting facemask. The Center for Disease Control (CDC) COVID Data Tracker indicated Hennepin County community transmission level was high on July 28, 2022. The CDC COVID-19 PPE and Source Control Grids dated April 7, 2022, indicated when a community transmission level was high, staff working with residents without COVID-19 should wear a face mask and eye protection. During an observation on July 28, 2022, at 8:30 a.m., unlicensed personnel (ULP)-C was not wearing a face mask or eye protection when in resident care areas. During an interview July 28, 2022, at 8:30 a.m., ULP-C stated he had asthma when asked why he wasn't wearing a facemask or goggles. ULP-C denied he had medical approval to work without required PPE. During an interview on July 28, 2022, at 11:10 a.m., licensed assisted living director (LALD)- B said all staff must wear a face mask while working at the facility. LALD-B stated she was unaware staff needed to wear goggles while working within six feet of the residents.	0 510		

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0 510	Continued From page 3 The licensee's undated Amerigrace Home Care LLC COVID-19 Preparedness Plan policy indicated all staff should wear a face mask and eye protection while in the facility. Staff and Visitor Screening The licensee failed to screen licensee staff and visitors, including surveyors, for temperature and symptoms of COVID-19 prior to entering the facility. The CDC guidance document titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) updated February 2, 2022, indicated a process should be in place to identify anyone entering the facility, regardless of their vaccination status for COVID-19. Options could include screening upon arrival at the facility. According to the COVID-19 staff screening log, the log lacked documentation of staff screening for COVID-19 upon the start of their shift. During an interview on July 28, 2022, at 11:10 a.m., LALD-B, reviewed and acknowledged the lack of COVID-19 screening documentation for staff. LALD-B said staff should be documenting temperature and symptoms prior to the start of their shift. The licensee's undated Amerigrace Home Care LLC COVID-19 Preparedness Plan policy indicated all staff at the start of their shift will be screened for COVID-19 symptoms. TIME PERIOD FOR CORRECTION: Two (2)	0 510		

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