

MALTREATMENT INVESTIGATION MEMORANDUM
Office of Inspector General, Licensing Division
Public Information

Minnesota Statutes, section 626.557, subdivision 1 states, "The legislature declares that the public policy of this state is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment."

Report Number: 202208895

Date Issued: June 23, 2023

Name and Address of Facility Investigated:

Disposition: Inconclusive

Minnesota Sex Offender Program
100 Freeman Drive
Saint Peter, MN 56082

License Number and Program Type:

830611 – Minnesota Sex Offender Treatment Program/Psychopathic Personality

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that when a vulnerable adult (VA) experienced significant decline in mental and physical health, health care professionals (HCPs) refused to assist the VA when s/he displayed symptoms of incontinence, confusion, immobility, and inability to comply with medical directives. In addition, the VA was transferred from the facility in St. Peter to the Minnesota Sex Offender Program in Moose Lake (MSOP Moose Lake) where it was believed his/her care was misrepresented as being independent. After reassessment, the VA was transferred to a Forensic Nursing Home (FNH).

Date of Incident(s): Prior to October 2022

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (b), and Minnesota Statutes, section 626.5572, subdivision 15, and subdivision 17, paragraph (a):

The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision which is reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult and which is not the result of an accident or therapeutic conduct.

Summary of Findings:

Pertinent information for this investigation was obtained remotely, including documentation from the facility, MSOP Moose Lake, and the FNH; and through eight interviews conducted in person or via telephone with facility staff persons (P1, P5, and P7), and facility health care professionals (HCP1, HCP5, HCP6, and HCP7). This investigator also met and interviewed the VA at the FNH.

The VA's diagnoses included pedophilia, personality disorder, chronic obstructive pulmonary disease (COPD), and prostate cancer. Facility documentation showed that in March 2022, the VA used a wheeled walker to assist with ambulation as well as a wheelchair as needed for long distances. The VA also used a portable oxygen tank and concentrator.

The VA's *Vulnerable Adult Assessment* showed the following:

- The VA had identified physical or mental health conditions resulting in difficulty with daily cares like cutting his/her fingernails, making a bed, and washing his/her laundry.
- The VA had "episodic forgetfulness" and "multiple sources indicated [s/he] has difficulty with following directions." The VA wandered around the unit and had difficulty at times remaining clothed while the door to his/her room was open "all the while insisting [s/he] is clothed." The VA needed reminders to eat meals and to charge his/her global positioning system (GPS) bracelet.
- The VA's breathing issues resulted in altered thinking and the need to use a walker as well as other medical conditions which posed difficulty for the VA to protect him/herself from abuse.
- The VA was determined to be a vulnerable adult.

The following information regarding the VA's moves between facilities was obtained from various facility documents, an *Internal Review*, and interviews:

- In July 2022, the VA resided at Community Preparation Services (CPS), also called Green Acres. (CPS was part of the Minnesota Sex Offender Treatment Program but was located outside of the secure perimeter of the facility in Saint Peter, MN.) In order to reside at CPS, a client needed to petition a Special Review Board and a Supreme Court Appeal Panel and be granted a transfer for a reduction in custody. CPS clients had GPS monitoring, participated in facility "counts" to account for their presence, and were subject to room searches and drug testing.

- HCP7 worked with the VA when s/he resided at CPS. Initially, the VA showed “good awareness” and self-administered his/her medications with the use of a medication minder. When unidentified HCPs observed the VA was not always taking his/her medications as prescribed (s/he took medications at the wrong time or not at all), the VA had to come to the clinic (located on campus) twice per day to get his/her medication. HCP7 described the VA as “unkempt” and said the VA did not have many clothes so s/he had to do laundry frequently. The VA did not consistently change his/her clothing or shower and required daily prompting. When the VA demonstrated “confusion,” HCP7 questioned whether the VA had dementia or was malingering, and an initial cognitive test was completed and showed the VA scored “average” for a person of his/her age.
- In September 2022, while residing at Green Acres West/CPS, the VA’s *Individual Abuse Prevention Plan* stated that s/he was “disoriented during the evening/nighttime hours and tried to walk out of the side door of [his/her] living unit,” and/or had gotten “lost.” The VA was at risk for harm due to upcoming colder winter months if s/he left the unit at night and was disoriented. Staff persons were to visually verify the VA was on his/her living unit during each 30-minute round. At that time the VA was also unable to report maltreatment and although able to shower independently, s/he had difficulty remembering to shower or wear appropriate clothing and numerous times was observed nude from the waist down in areas that were not private.
- On October 13, 2022, the VA was moved from CPS to Pexton 2 South (an Extended Care Unit (ECU) located inside the facility’s secure perimeter) due to his/her medical decline and concerns for his/her safety. At that time the plan was to transfer the VA to MSOP Moose Lake for additional assistance with his/her cares. On that same day, HCP7 updated the VA’s *Nursing Care Plan* and indicated that the VA was able to use the bathroom independently, was able to ambulate with a walker, and that while the goal was for the VA to remain as independent as possible regarding self-care, when it came to dressing, grooming, bathing, eating, and oral hygiene, the VA required “assistance as needed” and was provided prompts. That same day, a staff person (P8) documented that the VA ate his/her evening meal and “was able to utilize the toilet on [his/her] own.”
- On October 14, 2022, the VA tested positive for COVID-19 and moved from the ECU to Shantz 2 East (located on the facility campus) for the required 10 days of isolation.
- On October 21, 2022, the VA showed a decline in ability to care for his/her self-care needs and required staff persons to assist him/her with showering, changing clothes, etc. However, according to an *Internal Review*, during a care conference that same day between multiple medical staff persons at the facility and MSOP Moose Lake, HCP1 and HCP7 provided information that the VA was independent and did not need placement on the assisted living unit at Moose Lake for medical reasons. (There was no documentation found of the care conference to include the rationale for the transfer or documentation regarding the client’s abilities prior to his/her transfer to MSOP Moose Lake.)
- On October 24, 2022, the VA was transferred to MSOP Moose Lake for continued care and treatment needs.
- HCP7 said that prior to being diagnosed with COVID-19, the VA independently ate, showered, and walked with a walker and/or used a wheelchair.

- P7 said that prior to being diagnosed with COVID-19, the VA was able to independently shower. P7 said that once the VA was diagnosed with COVID-19, s/he “struggled a lot” and needed reminders to wear his/her oxygen. The VA’s speech was not always coherent, and s/he gave a one-word response or “grunt.” Sometimes the VA said his/her oxygen was not working despite staff persons checking the oxygen and confirming it was working correctly. Even when prompted, the VA sometimes refused to wear his/her oxygen.
- HCP6 said that prior to the VA’s transfer from the facility to MSOP Moose Lake on October 24, 2022, there was “a lot of discussion” and information presented showed that the VA “did not need” assistance and the move was more related to the VA’s wandering since s/he resided at CPS, outside the secure perimeter. However, once the VA arrived at MSOP Moose Lake, it was determined the VA needed “hands on” assistance from both health care professionals and facility staff persons. HCP6 did not know how much assistance the VA needed prior to being diagnosed with COVID-19 and it was “challenging” to determine if being diagnosed with COVID-19, being placed in isolation, and then being transferred directly to MSOP Moose Lake exacerbated his/her need for assistance. Regardless, due to the level of care the VA needed, on October 28, 2022, s/he was transferred to the FNH.
- On October 29, 2022, HCP5 met the VA at the FNH and the VA said s/he needed assistance with dressing and personal hygiene. HCP5 said that documentation showed the VA was independent when eating.

Regarding the HCPs refusal to assist the VA with care:

HCP1 said that prior to the VA’s COVID-19 diagnoses, the VA did “everything” him/herself. Including dressing, moving about, and switching his/her oxygen from “concentration to portable.” The VA’s decline in ability to complete his/her own self cares began around October 21, 2022.

P5 provided the following information on an *Incident Report* dated October 21, 2022, and/or during an interview with this investigator:

- Two HCPs (HCP4 and HCP8) were called after the VA was incontinent of bowel and bladder and showed signs of confusion.
- HCP4 said that “health services” saw the VA an hour prior and his/her vitals were “fine,” and health services were “not staffed to dress or bathe” the VA.
- The VA remained in his/her own feces for over an hour while staff persons (P5 and P7) prompted the VA to clean him/herself up and change clothes.
- The HCPs were called a second time and informed that the situation had not changed. HCP4 told P5 that staff persons should keep prompting the VA and if s/he did not follow directives, the VA should be issued a *Behavioral Expectation Report (BER)*. P5 reminded HCP4 that the VA was determined to be a “vulnerable adult and a CPS client.” (The VA was not issued a *BER*.)
- An officer on duty (P9) was called and additional staff persons responded to assist the VA with showering,

changing into clean clothes, and helping the VA to his/her room. An unidentified HCP “showed up” after the VA’s shower was completed and checked the VA’s vital signs.

- P5 said that neither staff persons nor HCPs generally assisted clients with showering, and because it was a “gray” area s/he contacted health services.

Following the incident, HCP4 stated that at the time of the call for assistance (on October 21, 2022), it was believed the VA was independent with cares. Additionally, the HCPs were not immediately available because they were performing other health care duties.

When interviewed by this investigator, the VA remembered having “no control” over his/her bowels when s/he had COVID-19. The VA said that staff persons helped him/her with showers for what “seemed like days.”

Additional *Incident Reports* for October 23 and 24, 2022, and/or interviews with this investigator provided similar information regarding staff persons (P1-P6) and a health care professional (HCP1) assisting the VA after incidents of soiling him/herself.

Regarding the VA’s weight loss:

During the course of the investigation, there were concerns that the VA lost a significant amount of weight (38 pounds) over a short period of time (approximately four weeks). Information from the investigation provided the following information:

- Documentation showed that staff persons prompted the VA for meals according to his/her nursing care plan. In addition, information showed the VA’s weight loss may have been related to his/her COVID-19 diagnoses.
- On October 14, 2022, (while the VA was in isolation) documentation showed that s/he only ate a few bites of his/her breakfast and was given extra juice because s/he “didn’t have much of an appetite.”
- P1 had “very limited” interaction with the VA and was not aware of any weight loss.
- P7 worked with the VA consistently and believed the VA lost 20-30 pounds between August and November, 2022.
- P5 said that when s/he worked with the VA when the VA was in isolation due to COVID-19, the VA was able to feed him/herself.
- HCP6 said that s/he reviewed documentation that showed on October 10, 2022, the VA weighed 160 pounds. HCP6 did not have information regarding what kind of scale was used with the VA at the facility. (This investigator did not locate a weight for the VA for October 10, 2022; however, did locate a weight for September 28, 2022, of 168 pounds.) On October 24, 2022, after arriving at MSOP Moose Lake, a wheelchair scale was used, and the VA weighed 130 pounds (a loss of 38 pounds in approximately four weeks). On November 9, 2022, the VA weighed 152 pounds (a gain of 22 pounds in 16 days).

- The VA said that in the summer of 2022, s/he believed s/he weighed approximately 200 pounds. At that time, the VA was “trying to lose weight” and after losing 19 pounds, “all the sudden it flew off me” and the VA thought s/he currently (November 2022) weighed about 135 pounds. The VA said when s/he had COVID-19, and during that time s/he was able to feed him/herself.

Facility information showed that staff persons were trained regarding the Reporting of Maltreatment of Vulnerable Adults Act.

Conclusion:

Information showed that the VA had multiple moves within two weeks as a result of his/her cognitive decline, need for safety, and/or medical necessity due to COVID-19. The VA first resided on CPS, and then for safety reasons, moved to the ECU. Although the initial plan was for the VA to move to MSOP Moose Lake, the morning after moving to the ECU, the VA tested positive for COVID-19 and had to move again within the facility so that s/he could be isolated for 10 days. While the VA was in isolation, s/he experienced several episodes of incontinence and required physical assistance to shower and change his/her clothing. During that same period of time, information showed the VA lost a significant amount of weight despite staff persons prompting the VA to eat.

Regarding the HCPs refusal to assist the VA with care:

Information showed that on October 21, 2022, the VA was incontinent of bowel and bladder and showed signs of confusion, so the assistance of an HCP was requested. Documentation showed that P5 told HCP4 what was going on and HCP4 said that if the VA was non-compliant, s/he should be given a *BER* for not following directives (to shower/change). Neither HCP4 nor HCP8 responded to the unit until more than an hour later, and by then additional staff persons were called to the unit to assist with showering the VA and changing the VA’s clothing.

Given that P5 said bathing clients was a “gray” area and was not typically done by staff persons or HCPs, that there was no information that any harm came to the VA due to waiting about an hour to shower after being incontinent, that HCP4 believed the VA was independent with self-care, and that HCP4 said an HCP was not immediately available because they were performing other health care duties, there was not a preponderance of the evidence whether there was a failure to provide the VA with reasonable and necessary health care to maintain his/her physical or mental health or safety.

Regarding concerns that the VA’s care was misrepresented:

When the VA eventually moved to MSOP Moose Lake as originally planned, the VA’s ability to independently complete many self-care tasks declined and s/he required both verbal and physical assistance. Although it was believed the VA’s care was misrepresented, given that information showed that the VA’s decline was recent, and likely due to his/her COVID-19 diagnoses as well as the multiple moves over a short period of time, there was not a preponderance of the evidence whether there was a failure to provide the VA with reasonable and necessary health care to maintain his/her physical or mental health or safety.

Regarding concerns about the VA’s weight loss:

Information showed that the VA weighed 168 pounds on September 28, 2022, while residing at the facility. When the VA was weighed on a wheelchair scale at MSOP Moose Lake four weeks later, the VA weighed 130 pounds. However, on November 9, 2022, the VA weighed 152 pounds (a gain of 22 pounds in 16 days) thus showing how rapidly the VA's weight fluctuated. Given that the VA was diagnosed with COVID-19 just prior to his/her admission to MSOP Moose Lake; that the first day in isolation it was documented the VA did not have much of an appetite; that documentation and interviews also showed that the VA was prompted to eat and was able to feed him/herself when in isolation; and that the VA promptly started gaining weight once his/her COVID-19 isolation ended, there was not a preponderance of the evidence whether there was a failure to provide the VA with reasonable and necessary health care to maintain his/her physical or mental health or safety.

It was not determined whether neglect occurred (the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision which is reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult and which is not the result of an accident or therapeutic conduct).

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were not adequate and were not followed. Specifically, a client orientation record was not completed for any of the VA's moves between units/locations as required by the *MSOP Client Placement Policy*. Staff persons were provided retraining regarding that policy. The facility also identified multiple areas to address such as one staff person was not up to date with vulnerable adult training (since rectified), updating guidelines for interventions and approaches in the *Nursing Care Plans* for clients to reflect the unit/environment and to provide clearer guidance for staff persons, and expectations for documenting a summarization of care conferences in an *Individual Progress Note*.

Action Taken by Department of Human Services, Office of Inspector General:

No further action taken.