Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H7292043M
Compliance #: H7292042C

Date Concluded: August 5, 2022

Name, Address, and County of Licensee Investigated:
Mary T Home Health
299 Coon Rapids Boulevard #105
Coon Rapids, Minnesota 55433
Anoka County

Facility Type: Home Care Provider

Evaluator's Name: Nicole Myslicki, RN
Special Investigator

Finding: Substantiated, individual responsibility

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) sexually abused the client when the AP fondled the client's genitals and performed oral sex on him.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP performed oral sex on the client.

The investigator conducted interviews with the facility's nurse, the client and the client's family member, and the AP. The investigator contacted law enforcement. The investigation included review of the client's medical record, the facility's internal investigation, policies including vulnerable adult, emergency procedures, and incidents involving clients.

The client received comprehensive services in his home. The client's diagnoses included diabetes and high blood pressure. The client's service agreement included assistance with medication set up, skilled nursing visits, and help with meal preparation and bathing once weekly. The client's assessment identified the client as oriented to person, place, and time, but forgetful.

An investigation completed by the facility indicated the client informed multiple staff members that during a home health visit, the AP taught the client how to watch porn and watched it together. Additionally, the AP fondled him in the bathtub. After this, the AP directed him to his bed where they attempted to have sexual intercourse, but the client could not perform, so the AP performed oral sex on the client. The client informed staff members he felt ashamed about what happened. This internal investigation also indicated the AP admitted to showing the client pornography and how to find it online but denied she had sexual intercourse with him or performed oral sex on him.

The AP completed a home health visit and documented providing services including assistance with bathing, dressing, housekeeping, and meal prep the day the incident occurred.

Approximately one week later, another unlicensed personnel visited the client to provide bathing assistance. The client informed the unlicensed personnel of the incident.

During an interview, the nurse stated she received a call from the unlicensed personnel who informed her of the incident. The nurse then spoke with the client who informed her the AP performed oral sex on him. The client stated he did not ask the AP to do this, but she did it on her own. The following day, the client called the nurse and informed her he felt ashamed, and he apologized for the situation. She provided reassurance regarding his role in the incident. The nurse stated after this incident, the client appeared to be confused about professional boundaries with the facility's staff.

During an interview, the AP stated she showed the client a pornography site on her phone. The AP felt concerned after speaking with the client that he wanted to solicit sex from a stranger, so she showed him a way to access pornography to keep him from leaving the home to seek out sex.

During an interview, the client described the AP as helpful and friendly. He talked with the AP about wanting to watch pornography online, and the AP proceeded to show him how to find it. The AP also gave the client "homework" regarding finding pornography and what he liked. The next time the AP came to give the client his bath, she left the client in the bathroom after assisting him. The client went to the bedroom looking for the AP and found she closed the curtains and placed a pillow sideways on the bed. The AP instructed him to lay down. The AP proceeded to fondle the client. The AP pulled her shirt up and her pants down and physically assisted the client to touch her genitals. The client stated he and the AP attempted to have

sexual intercourse, but he could not perform. The AP performed oral sex on the client, then cleaned up and left his home as usual. The client stated he did not know at the time the AP had given her resignation notice to the facility. On his next bath day, he had a different staff person. The client stated he thought she would do what the AP did, so he tried to massage her. The staff person stopped him and notified the facility immediately after leaving his home. When the facility called the client about his behavior, he explained what the AP did during her last visit.

During an interview, a family member stated the client did not know how to look things up on his phone or computer, so he had to have been shown how to find pornography websites. The client felt embarrassment over the incident but described it in detail to the family member. He stated during a bath, the AP started asking questions about his penis, and after learning about his erectile dysfunction, told the client she could help him. They went into the client's bedroom and attempted to have sexual intercourse.

In conclusion, the Minnesota Department of Health determined abuse was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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.
(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: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation, including interviewing other clients the AP worked with, re-educated staff on vulnerable adults and maltreatment, and contacted law

enforcement. In addition, the facility instructed the client not to answer the door if the AP returned to the house, not to answer the AP's calls, and to notify the facility if the AP attempted to contact him. The AP is no longer employed by the facility.

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
Anoka County Attorney
Andover City Attorney
Andover Police Department

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247292	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY T HOME HEALTH	299 COON RAPIDS BLVD SUITE 105 , COON RAPIDS, Minnesota, 55433

(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) COMPLETION DATE
00000	Initial Comments The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H7292043M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders are issued for #H7292043M, tag identification 325. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	00000		
00325	Free From Maltreatment CFR(s): 144A.44, Subd. 1(a)(14) 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one	00325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Minnesota State Department of Health

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00325	Continued from page 1 clients reviewed (C1) was free from maltreatment. C1 was abused. Findings include: On August 5, 2022, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	00325		