Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H80818882M
Compliance #: H80819185C

Date Concluded: February 11, 2026

Name, Address, and County of Licensee Investigated:
Regency Home Healthcare Service
10467 93rd Avenue North
Maple Grove, MN, 55369
Hennepin County

Facility Type: Home Health Agency (HHA)

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Investigation:
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 client when he hit him, cussed at him, and sexually abused him. The AP also abused the client by completing improper respiratory and range of motion (ROM) treatments which caused pain.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The client was in a persistent vegetative state (severe disorder of consciousness) from brain damage. Video footage showed the AP sexually, physically, and emotionally abuse the client. This included multiple incidences of rectal penetration, hitting, pulling the client's head up by his hair, and slamming his limbs to the bed. The AP repeatedly made foul, derogatory, and threatening statements to the client. The AP was a registered nurse. The AP forcefully and inappropriately suctioned the client's tracheostomy (surgical opening in the neck to create an airway). The client had two tube feeding ports, one to the stomach and one to the small intestines. The G-tube (gastric tube) was used for venting for

excess gas and drainage into a bag. The J-tube (jejunum/small intestine) was used for tube feedings. The AP switched the tube which caused excessive gas into the client's stomach causing pain and distress.

The investigator conducted interviews with agency staff members, including administrative staff, nursing staff. The investigation included review of the resident records, hospital records, agency internal investigation, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed video footage.

The client resided in his own home and received nursing care from agency staff. The client's diagnoses included quadriplegia (paralysis of all four limbs), myoclonus (sudden involuntary muscle jerking movement), and brain damage. The client was in a persistent vegetative state. The client's service plan included assistance with all activities of daily living (ADLs), medications, tracheostomy (trach) cares and tube feedings.

During an interview, a family member said the client had no independent mobility and required nursing care 24 hours per day. The family member said the client could not speak or independently move his body and had contractures (permanently tightened) limbs. The family member said the client's left leg contracted upward toward his chest and his right leg contracted straight outward. The client was totally dependent upon someone for all movement of his body but did move his eyes and appeared to understand some things. The client was incontinent (no control) of bowel and bladder and required someone to change him. The client received continuous feeding through his feeding tube. The family member said staff were to connect the client's feeding tube into the J-tube and the venting/drainage bag to the G-tube. The drainage bag should always remain connected to the G-tube port because it collects excess drainage and gas. The family member said after the AP competed his shift, they took over the client's care and noticed the client's gastric bag filled with fluid really fast which was unusual. Family was concerned and called the hospital. During this time, they discovered the AP switched the ports and connected the client's drainage bag to the J-tube port and his feeding into the G-tube port. This caused the client's feeding to go into his stomach. The family member said they had cameras in the client's room in case something occurred, so they could look back and discover what happened. The family member said they trusted the staff members, so they did not need to watch video footage routinely. The family member said they watched video footage to try to determine how the client's ports became switched. The family member said while watching video footage, they observed multiple instances of abuse from the AP to the client. The family member said they had video footage for three of the days the AP worked. The family member said they reported this to the agency where the AP was employed and to law enforcement. The AP did not return to their home.

During an interview, the agency manger said initially he received videos showing the AP "plugging" the client's nose. The AP also placed a towel over the client's head. Video footage showed the AP used excessive force for range of motion (ROM). The manager said he immediately suspended the AP. At this time, the manager said he implemented a training plan

for the AP; however, the family member gave him more videos which showed the AP sexually, verbally, physically, and emotionally abuse the client. The manager said he immediately terminated the AP.

Four days of video footage was reviewed.

Sexual Abuse:

Video footage showed the client had a bowel movement and the AP changed him. After the AP cleaned the client, he placed him onto his right side then put his left index finger into the client's rectum and aggressively pushed up and down. There appeared to be no clinical indication for this action.

Video footage showed the AP lift the client's penis by pubic hair and place it into a urinal. The AP did not wear gloves.

Audio and video footage showed the AP at the client's right side, with his back to the camera. The AP used an angry, aggressive tone and told him to go to sleep. The AP looked at the client and angrily asked him, "Want me to fucking stick my finger up your ass? Fine I will." The client was lying on his back at the time and the AP aggressively pushed the client's legs apart. The AP left the client, went and got gloves, and returned to him. Video footage showed the AP put on gloves. At this time, the client's brief was open, but the AP's back remained toward the camera so there was a partially obstructed view. The AP's right hand moved between the client's open legs towards the center of his body, which would be near his rectum. The AP turned his head and looked at the client, then moved his right arm move up as if he was pushing in an upward motion with a couple of aggressive strokes. The client's body moved up and down. The AP then placed a urinal under the client's penis, although there was no clinical need as the client did not have control over his bladder. After a couple of minutes, the AP removed the urinal and placed the client's legs on a wedge pillow. The AP never changed the client's brief and there appeared to be no clinical indication to touch the client's buttock region.

Audio and video footage showed the AP tell the client, he had a "big dick," then as he adjusted the urinal, he poked at the client's penis several times and said, "Right there, that fucker, huge." The AP did not wear gloves for this encounter.

Video footage showed an incident where the AP exposed his own genitalia to the client. Video footage showed the AP remove his belt from his black pants and pull them down slightly. The AP walked toward the client's bed and took a rolling office chair with him. He placed the chair at the foot of the client's bed. The AP removed the white blanket from the client's head/face. (He had placed a blanket over the client's head and face prior to this incident). The client's body was in an upright, sitting position. The AP went to the foot of the bed, where he placed the office chair, and removed his black pants. The AP wore grey long underwear pants underneath. The AP then got up, adjusted the client's bed and trach and returned to the foot of the bed. The AP then removed his grey underwear as he sat on the chair, directly in front of the client. The AP's

genitals were visible while he sat on the chair. During these events, he looked directly at the client. The AP then put on his black pants and walked over to the side of the client's bed.

Video footage showed the AP wash the client's buttocks after he had an incontinent stool. During this time, the AP had both his hands under the client's buttocks, while the client laid on his back with his left leg propped up. The client was not on his side as appropriate to conduct perineal care. The AP wedged his hand under the client's buttock where his rectum was. The AP turned his head to look at the client, removed his right hand but his left hand remained under the client. The AP then moved his left hand, which was under the client, presumably in or near the rectum based on positioning and in a rapid in and out motion as he appeared to push upward. His motion was aggressive and fast. The client's body moved up and down. The AP then removed his hand and looked at his glove. There appeared to be no clinical indication for this action. The AP never removed a soiled brief.

Physical Abuse:
Video footage showed multiple/frequent times where the AP opened the client's brief and aggressively shoved a urinal into his genitalia. This behavior occurred multiple times every shift the AP worked.

The client had contractures of his limbs. The client's left leg appeared bent at his knee with his leg/knee up toward his chest. The client's left leg could not extend outward and remained in this position. Video footage showed multiple incidents where the AP pushed and pulled the client's left leg aggressively. These actions appeared random, with no clinical indications for this behavior. Video footage showed an incident where the AP grabbed the client's left leg toward his foot, plant both his feet, then lean back and pull the client's leg. Video footage showed the AP's whole body leaned back. Through audio footage, the client's leg made "popping" and "crackling" sounds. Video footage showed multiple incidents where the AP slammed the client's left leg down on the bed.

Video footage showed multiple incidences where the AP lifted the client's head off his pillow by pulling his hair. One incident, the AP took his right hand and struck the client's left forehead, grabbed his hair, lifted his head off the pillow, and commanded him to close his eyes and "go to fucking sleep." The AP then pushed the client's head back down into his pillow. The AP put a blanket over the client's head/face.

Video footage showed an incident were the AP stood at the client's head of the bed and with both his hands, reached under the client's shoulders, grabbed the blanket from under him and bounced the client forcefully up and down. During this encounter the client's neck extended backward. The AP shook and bounced the client so hard, his whole upper body elevated from the bed. After the AP shook and bounced the client several times, he pulled the client's body upward toward the head of the bed. The client's head hit the headboard of the bed. In another incident, the AP slid the client up in bed, then lifted him up and slammed him down twice. During this time, the client's head and shoulders bounced up and down on the mattress.

Emotional Abuse:
Audio and video footage revealed the AP used repeated, threatening language and actions toward the client. The AP called the client a “fucker,” “fucking dick,” and “fucking asshole.” The AP lunged at the client in a threatening manor when he said some of these things. The client was unable to speak or move. One incident, the AP lunged at the client with a closed fist and commanded him to go to sleep and asked him, “What the fuck is your problem?” Another incident, the AP taunted the client by repeatedly putting a towel/blanket on and off the client’s head. At this time, the AP told the client to smile because he was on “candid camera.”

Actions to Inflict Pain:
The client’s care plan indicated he required skilled nursing (licensed/registered nurses) care 24 hours per day. The client required nurses to perform tracheostomy care including suctioning and oxygen. The records indicated the client required a tube connected to his trach collar (neck) continuously while he was in bed. Through this tube, the client received humid air which prevented thick mucus and blockages of the trach tube. Nurses were to suction the client’s trach with the prescribed suction catheter and push it down into the client to the designated length. The care plan indicated the tube protruding from the client’s stomach contained two ports. One port was for the J-tube, the other the G-tube. The J port was to connect to the client’s feeding tube and the G port connected to the drainage/venting bag. The drainage bag should always remain connected to the client. The client received all medications through the J-tube.

Video footage showed the AP suction the client multiple times orally. One instance, the AP aggressively shoved the suction tubing down the client’s throat repeatedly which caused the client’s face to get red, and his body tense up and twitch. While pushing the tubing down the client’s throat the AP said, “I don’t give a fuck.”

Video footage showed multiple times where the AP pinched the client’s nose shut while he received various respiratory treatments.

Video footage indicated the AP switched the client’s feeding tube and gastric tube which caused the tube feeding to go into the client’s stomach as opposed to his jejunum (small intestine).

Hospital records indicated the client went to the hospital after this incident. Hospital records indicated the client’s tube feeding entered his stomach for over ten hours. This caused distention (enlargement) of his abdomen.

During an interview, a nurse said the client required oral (mouth) and trach suctioning. The nurse said the client only required suctioning of his mouth around his teeth. The nurse said they are not supposed to put the suction tube down the client’s throat. The nurse said the suction tube contained a mark which indicated how far to push the tube down into the client when they suctioned through his trach. The nurse said the gastric tube contained clear identification

for each port. The nurse said the gastric bag remained connected to the client all the time. The nurse said there would be no need to disconnect both tubes at the same time.

The AP's employee file indicated the agency provided vulnerable adult training prior to his employment and additionally training for trach care. The AP's employee filed contained an email sent to him from his manger. The email indicated the agency told the AP they terminated his employment due to video evidence of abuse. The AP responded he had never done anything to the client to put him in immediate distress. The AP said his termination was not "fair."

Law enforcement records indicated the AP told them he did use excessive force with a few range of motion exercises and was trying to improve the client's situation, not hurt him. The records indicated the AP admitted to swearing at the client once or twice due to frustration. The records indicated the AP denied being physically aggressive or assault the client. The records indicated the AP put his finger in the client's rectum to stimulate bowel movements. The records indicated the AP was aware video cameras were present in the home. The records indicated the AP worked with the client for approximately six months.

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.
(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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):
(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No. Unable.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No. Did not respond to request.

Action taken by facility:
The agency immediately terminated the AP.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility noncompliance. 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.

You may also call 651-201-4200 to receive a copy via mail or email.

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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
Dodge County Attorney
Kasson City Attorney
Kasson Police Department
Minnesota Board of Nursing

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/07/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HOME HEALTHCARE SERVICES, LLC	**10467 93RD AVENUE NORTH , MAPLE GROVE, Minnesota, 55369**

(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 #H80818882M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for #H80818882M, tag identification 325.	00000		
00325	Free From Maltreatment CFR(s): 144A.44, Subd. 1(a)(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: The facility failed to ensure one of one client reviewed (C1) was free from maltreatment. The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	00325		

Office of Primary Care and Health Systems Management

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