DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HG286061M
Compliance #: HG286060C

Date Concluded: August 2, 2022

Name, Address, and County of Licensee Investigated:
Homeward Bound
7839 Brooklyn Boulevard
Minneapolis, MN 55445
Hennepin County

Facility Type: Intermediate Care Facility (ICF)

Evaluator's Name: Jill Hagen, 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)1 abused a client when AP1 fed the client using a syringe to force liquified food into the client's mouth. AP2 abused the client when during the feeding, AP2 held the client's head to prevent the client's refusal and movement when AP1 injected the liquified food into the client's mouth.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. AP1 and AP2 were responsible for the maltreatment. When the client refused to eat, AP1 thinned the food with

milk, drew the liquid into a syringe and injected the liquid into the client's mouth while AP2 held the client's head to prevent movement. The client's care plan directed staff to assist the client to eat using a spoon with quarter sized soft foods.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the client's medical record, staff schedules, policies and procedures for feeding assistance and abuse and neglect, and review of the federal on-site visit notes and observations.

The client resided in a home for the intellectually disabled with a diagnosis of profound intellectual disability. The client was non-communicative and required others to anticipate his needs. The client required assistance to complete all activities of daily living and one staff assistance to eat. The client's care plan directed staff to assist the client to eat mechanical soft foods (easy to chew) by the spoonful which were cut into quarter sized pieces and have regular thin liquids using a cup. The client had a history of pocketing food in his mouth. The vulnerable adult assessment indicated the client was not able to deal with verbally and/or physically aggressive persons.

A facility incident report indicated at the evening meal a witness observed AP1 dilute the client's food with milk, draw the liquid into a 60 cubic centimeter (cc) syringe, and inject the liquid food from the syringe into the client's mouth. AP1 asked AP2 to hold the client's head during the feeding. The witness did not know the amount injected into the client's mouth each time but observed the client's cheeks "puff out" with liquid coming out of the sides of the client's mouth. The client responded by moving his head rapidly from side-to-side as if to communicate "No".

The facility investigation indicated when interviewed AP1 stated he contacted an unidentified nurse regarding the client's refusal to eat. AP1 stated the nurse thinned the client's food with milk and proceeded to use a 60-cc syringe with the thinned liquid injecting the food into the client's mouth. The following evening, the client refused to eat so AP1 stated he thinned the client's food the same as the previous night and injected the liquid food into the client's mouth. AP1 stated the client did not move his head during the syringe feeding.

Management interviewed the nurse on-duty that evening who stated the client was refusing to eat, and the family planned to visit and would assist the client to eat. Because of that, the nurse stated she instructed staff to thin the client's food to a liquid so the client could drink his food from a cup. The nurse denied providing any verbal or physical direction to staff to use a syringe for feeding the client.

The facility investigation indicated when AP2 was interviewed he stated he was concerned the client had refused to eat for two days. AP2 approached AP1 about the client's refusals and AP1 suggested using a syringe instead of a spoon to feed the client. AP2 stated he supported the client and held the clothing protector throughout the meal. AP2 stated it was not good to use

the syringe to assist the client to eat but AP2 thought a nurse had approved the approach. It took approximately 30 minutes to assist the client with eating.

During an interview, the licensed staff working the evening of the incident denied instructing staff to assist the client to eat using a syringe. The licensed staff stated she would not jeopardize her license by instructing unlicensed staff to assist the client to eat using a syringe.

During an interview, AP1 stated the maltreatment was a false allegation against him and an unidentified nurse was the staff person that used a syringe to assist the client to eat.

During an interview, AP2 stated he supported the client by sitting him upright in his chair. AP2 observed AP1 thin the client's food with milk, fill a syringe with the thinned liquid and inject the liquid into the client's mouth. AP2 stated the client did not make any verbal or physical response during the feeding.

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; Stop here if it is not a restraints issue or sexual abuse.

(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: No, non-verbal.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes, both AP1 and AP2.

Action taken by facility:
Following the incident and after an on-site federal compliance survey, all staff received training on recognition, responding and reporting maltreatment of vulnerable adults. Staff education included increasing knowledge of permitted, restricted, and prohibited procedures. All staff received education about identifying client's non-verbal communication for pain and discomfort. Facility management reviewed and revised their maltreatment policy and procedure for reporting. AP2 was provided education on reporting prior to providing client care. AP1 was no longer employed by the facility.

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:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

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
Hennepin County Attorney

Minneapolis City Attorney
Minneapolis Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01273	A. BUILDING: ____ B. WING ____	C 07/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWARD BOUND BROOKLYN PARK	**7839 BROOKLYN BLVD BROOKLYN PARK, MN 55445**

(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
5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. The Minnesota Department of Health investigated an allegation of maltreatment, complaint #HG286061M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for #HG286061M, tag identification 0700.	5 000		
5 700	MN Statute 144.651 Subd. 14. RES. RIGHTS Freedom from maltreatment.	5 700		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Minnesota Department of Health

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5 700	Continued From page 1 Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on 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 July 25, 2022, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that two individual staff persons were 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.	5 700	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	