DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL20455015M
Compliance #: HL20455016C

Date Concluded: September 20, 2021

Name, Address, and County of Licensee Investigated:
Pioneer Estates
8761 Preserve Blvd
Eden Prairie, MN 55344
Hennepin County

Facility Type: Home Care Provider

Investigator's Name: Yolanda Dawson, 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.

Allegation(s):
It is alleged: the alleged perpetrator (AP) abused the client when he yelled and raised his fist towards the client.

Investigative Findings and Conclusion:
Emotional abuse was substantiated. The AP was upset that the client stated he was going to report him to management and responded in a manner that was threatening, harassing, and humiliating when the AP raised his fist and yelled at the client (who is a paraplegic) to get up and do something about it.

The investigation included interviews with facility staff, including administrative staff, nursing staff, unlicensed staff, and a case worker. The investigation included a review of the client's medical record, facility policies, procedures, incident reports and facility internal investigation.

The client's medical diagnoses included incomplete injury of spinal cord, quadriplegia, and chronic pain syndrome. The client received comprehensive home care services for medication

management, personal cares including weekly bathing assistance, dressing assistance, repositioning, catheter care, behavior management, two person assisted transfers, meal setup, and housekeeping.

One night, the AP and another staff member used a mechanical lift to transfer the client to bed. The client did not like the way the AP was handling him or the lift. The client and the AP argued about the proper way to use the lift. The client said that he was going to report the AP to management. The AP heard this and approached the client with verbal aggression and threatening behavior by getting close to his face and raising his fist. The other staff member physically removed the AP from the room.

Review of internal investigation notes indicated the client reported to management the AP was upset that ULP #1 asked him to help get him to bed. The client reported that he argued with the AP about how to position him in bed. After the client was in bed, the AP left the room, and the client stated he was going to report him. The AP overheard this and came back into the room, yelling at the client. The client said the AP came up to his bed, had his right hand on the side rail and his left hand in the air clenched in a fist. The client demonstrated to management that the AP's fist was approximately 12 inches above the client's chest. The client reported that if he was in his wheelchair, he would be able to protect himself, however, because he was in bed there was nothing he could do. ULP #1 reported that when the client told the AP to get out of his room, the AP yelled at the client to "get up and do something about it, oh wait you can't."

During an interview, the client stated that during the night shift ULP #1 and the AP were arguing when ULP #1 asked the AP for help to get him to bed. The AP responded by saying he was not going to help. The client stated the AP did come in and help with the mechanical lift, but he did not know how to use it. The client stated the AP was getting upset with ULP #1 because she was telling him how to maneuver the lift. The client stated the AP was upset when he took the lift out of the room. The client then asked ULP #1 who was that guy because I am going to talk to management, and it is going to be his last day. The client stated the AP came into the room and yelled at him that he heard that, puffed up his chest, and clenched his fist. The client stated he told the AP he did not want his help because of his attitude. The client stated he kept repeating to the AP to shut up and get out of his room.

During an interview, ULP #1 stated she and the AP were assisting the client to bed and the client did not like how the AP was handling him or the mechanical lift. ULP #1 stated the AP and the client started to argue, and she told the AP not to do this and told him to leave the room. The AP took the lift out of the room at which time the client asked ULP #1 the AP's name because he did not want the AP working with him anymore. The AP heard this comment and returned to the room and yelled "what are you saying why don't you say it to my face like a real man?" ULP #1 stated the client responded by saying he did not want to talk to AP. ULP #1 stated the AP then said, "why do you have to talk behind me like a bitch?" ULP #1 stated she told the AP you should not talk to the resident that way. ULP #1 stated the AP walked up to the bed and got close to the client's face, to which the client told the AP repeatedly to get the hell

out of his room. The AP said, “come make me if you can get up.” ULP #1 confirmed to the investigator that the AP raised a fist at the client. ULP #1 stated the AP was getting too close to the client, and she had to push AP to get him to leave.

During an interview, the AP stated the client had a preference on how to use the mechanical lift, but he had used a lift for ten years. The AP stated the client does not tell you what he wants, and then gets mad. The AP stated his response to the client being upset was that he kept quiet and left the room. Then he heard the client say, this is his last day working in this place ever. The AP stated he responded by asking the client if he did something wrong and he was trying to help the client. The AP stated the client tries to get people fired. The AP stated the client prefers only females to help him. The AP stated his behavior was appropriate, he did not raise his voice and that he was just standing his ground, he did not threaten the client, and he did not use inappropriate language.

In conclusion, emotional abuse was substantiated.

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;

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No, the client was his own decision maker.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The alleged perpetrator was from a nursing agency and the facility will not employee the AP in the future.

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.

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
Hennepin County Attorney
Eden Prairie City Attorney
Hennepin County 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
	H20455	A. BUILDING: ______ B. WING ______	C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER ESTATES OF EDEN PRAIRIE	**8751 PRESERVE BOULEVARD EDEN PRAIRIE, MN 55344**

(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 ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to an 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: ********REVISED********* On June 11, 2021, the Minnesota Department of Health initiated an investigation of complaints HL20455012C/HL20455011M and HL20455016C/HL20455015M. At the time of the investigation, there were #25 clients receiving services under the comprehensive license. The following correction order is issued issued for #HL20455016C#HL20455015M, tag identification 0325.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the investigators' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for licensing order follow-ups. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment 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:	0 325		

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0 325	Continued From page 1 (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 MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one clients (C1) reviewed was free from maltreatment. C1 was abused. Findings include: On June 11, 2021, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that the facility/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.	0 325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	