Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL21807001M
Compliance #: HL21807002C

Date Concluded: September 29, 2021

Name, Address, and County of Licensee Investigated:
Family Choice Homecare
2486 Pond Circle West
Mendota Heights, MN 55120

Facility Type: Home Care Provider

Investigator's Name: Peggy Boeck, 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 that the Alleged Perpetrator (AP), facility staff, abused a resident when the AP slapped and swore at the resident.

Investigative Findings and Conclusion:

Abuse was substantiated. The AP was responsible for the maltreatment. The AP became frustrated while cleaning up the resident's bowel movement and slapped the resident on the arm. When the resident had a second bowel movement the AP slapped the resident's arm again and swore at the resident.

The investigation included interviews with facility staff, including administrative staff and nursing staff. In addition, law enforcement was contacted as well as family. The investigator observed staff interaction with the resident, reviewed medical records, facility policies and procedures related to staff orientation, staff conduct, and maltreatment of vulnerable adults.

The resident lived in the facility for many years due to diagnoses that included Spina Bifida and ventilator dependence. The resident had impaired circulation, skin sensation, paralysis of lower extremities, left arm, and lack of head support due to Spina Bifida. The resident received services from the home care provider that included hourly nursing assessments, ventilator monitoring 24 hours per day, tracheostomy cares, lung treatments, gastrostomy tube cares, provision of nutrition, skin assessments, daily living cares, and medication administration. The facility provided 24-hour nursing care to the resident.

One morning while receiving morning cares, the resident told the nurse that the AP slapped him the previous night. The resident said the AP turned the resident while changing his incontinence brief and slapped the resident on the arm. The resident then told the nurse that he had another bowel movement later in the night and when the AP changed him again, she slapped his arm again. The resident told the nurse that the AP also swore and used the "F" word while cleaning up the resident.

During an interview, the nurse said she asked the resident if he was sure it was not a slip of the hand, and the resident was adamant that the AP intentionally slapped him. The nurse said she slapped her own arm as an example for the resident to have him describe how hard the slap was. The nurse said she slapped her own arm very hard, and the resident said that he did not have much feeling in that arm, but it sounded just like that. The nurse said the resident had never made a complaint before and she believed he told the truth. The nurse said she immediately reported the allegation to the owner.

During an interview, the owner said that when she spoke with the resident and the nurse, she learned that the resident felt the AP was upset with him when he had a bowel movement. The owner said the resident stated the AP hit him on the arm with an open hand when he had a bowel movement and shortly after that, the AP hit him again. The owner said she reassured the resident that the AP would not be back. The owner said the resident worried it was his fault.

Later in the day, the owner spoke with the AP, who told her that she (the AP) had a very frustrating night with the resident. The AP told the owner that while changing the resident, the sling caught the toilet, and bowel movement got all over the place and then the resident did it again (had another bowel movement). The owner made a report to the police, who began an investigation.

The police interviewed the resident, who said that the AP slapped him twice with an open hand and appeared frustrated when he had a bowel movement. The police interviewed the AP, who said she had difficulty getting the resident into the sling and got frustrated. The AP told the

police she had trouble moving the resident, her back hurt, and then the resident had another bowel movement. The AP told the police that she “did not hurt” the resident, “never hit” the resident, but admitted to swearing out of frustration.

During an interview, the resident said that on the night of the incident, he had two large bowel movements and the AP got mad and slapped his arm twice while she cleaned him up. The resident said the AP swore at him using the “F” word. The resident said he knew it was not right, so he told the next nurse who came in. The resident said he could tell the AP was not happy and that she got mad quickly. The resident said he was afraid she would come back into his room to assist with cares.

The AP declined to interview with the investigator.

At the time of the investigation the AP had been charged with a gross misdemeanor for mistreatment of persons confined and misdemeanor disorderly conduct, with an upcoming court date.

In conclusion, 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.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No, the AP declined to interview

Action taken by facility:
The AP no longer works at 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.

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
Mendota Heights Police Department
Mendota Heights City Attorney
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21807	A. BUILDING: _____ B. WING _____	C 09/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CHOICE HOMECARE	2486 POND CIRCLE WEST MENDOTA HEIGHTS, MN 55120

(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 a survey. 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: On September 21, 2021 the Minnesota Department of Health initiated an investigation of complaints #HL21807001M/ HL21807002C. At the time of the survey, there was one client receiving services under the comprehensive license. The following correction order is issued for #HL21807001M/ HL21807002C, 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	0 325		

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0 325	Continued From page 1 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 MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was abused. Findings include: On September 21, 2021, 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.	0 325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	