Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL25489017M
Compliance #: HL25489018C

Date Concluded: April 5, 2022

Name, Address, and County of Facility Investigated:
Accessible Space Inc. 4 ASI
2749-11th Avenue South
Minneapolis, MN 55407
Hennepin County

Facility Type: Home Care Provider

Evaluator's Name: Lori Pokela R.N.
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) had not put the client on the bedpan, stated to the client that she hoped she would die in a hospital and that the client is too heavy, fat and should be in a nursing home.

Investigative Findings and Conclusion:
Abuse was substantiated. The AP treated the client in a humiliating and harassing manner when the AP did not put the client on her bedpan, stated to the client that she hoped the client would die in a hospital, and stated the client was fat and should be in a nursing home.

The investigation included interviews with facility staff members, including nursing staff. The client's medical records were reviewed. Facility policies, incident reports and training records were reviewed.

The client's diagnoses included: post-polio and breathing issues. The client needed staff assistance with most activities of daily living, used a mechanical lift for transfers and wore a back brace.

An incident report from the dayshift, completed by the AP, indicated the client rang her call light to use the bedpan and the AP informed her that she (the AP) was running behind schedule. This facility 's incident report also indicated the AP had the client up forty-five minutes behind the client's regularly scheduled time.

The same day, another facility incident report was completed by an evening shift direct care staff member. This incident report indicated that the client was upset that the AP had not answered her call light for approximately fifteen minutes. When the AP did respond to the call light, the client told the AP she needed to use the bedpan and the AP responded by telling her that it was not her time yet and there was another client in the bathroom where the client's bedpan was located. This incident report indicated the client proceeded to use her call light several times, and when the AP responded, the client said the AP said nasty things that the client did not want to think about.

Three days afterwards, the facility investigated the incident. The investigation contained an interview between the administrator and the client. In this interview, the client told the administrator she was not sure what time she turned on the call light and the AP answered and informed the client it was too early, someone was in the bathroom. The client stated that when the bathroom became available, she turned on her call light again and the AP gave her the bedpan and completed morning cares. The client stated that approximately one month earlier, the AP told the client that the AP hated the client and hoped she would end up in bed next to another sick client. The client stated that on other dates, the AP told the client she was too heavy and hard to get up, and that the AP would not get up the client that day.

Also during the facility investigation, an unlicensed personnel (ULP) stated that the evening of the incident, he went to the client's room and observed the client being upset. The client told the ULP that the AP would not give her the bedpan when she turned on her call light and was told by the AP that it was not her time, and someone was in the bathroom where the client's bedpan was located. The ULP told the administrator that while he did not hear the comments himself, the client told him at the time that the AP said to the client that she is too fat, should be in a nursing home, and that the AP wished the client would get sick and die.

The client's service summary indicates the date of the incident, early in the morning, the client had a large bowel movement, and the AP signed that morning cares had been completed.

During an interview, the client stated the AP had told the client that she hated her and hoped she would have ended up in a hospital bed next to a client that had passed away from COVID-19. The client stated she was surprised and hurt the AP would say that.

During an interview, the ULP stated the client told him that the AP had been intimidating her for several months and the one thing that the client said had really upset her was that the AP told the client that she wished the client would get sick and go in a hospital bed and die. The ULP stated the client was crying as she told him. The client asked the ULP not to tell anyone that the AP told the client she is too heavy and ready for the nursing home.

During an interview, the facility's administrator stated the ULP reported the incident via text, and the administrator directed the ULP to write up a report of the incident. The administrator stated she interviewed the client, and the client stated the AP told the client that she wished she were dead. The administrator removed the AP from the schedule, and later transferred the AP to another facility.

During an interview, the AP stated she remembered the client asking for the bedpan as soon as the other person was out of the bathroom, the client was given the bedpan. The AP denied saying anything about hoping the client would get sick and die.

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;

(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 client, 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: Yes
Family/Responsible Party interviewed: No. Client is responsible party
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The AP was placed with another facility within the same organization.
The facility conducted a Vulnerable Adult Refresher Course for all staff.

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, 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
Hennepin County Attorney’s Office
Minneapolis City Attorney
Minneapolis Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H25489	A. BUILDING: _____ B. WING _____	C 02/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASI METRO 4	2550 UNIVERSITY AVE STE 330N SAINT PAUL, MN 55114

(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, these correction orders are issued pursuant to a complaint 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: #HL25489018C/#HL25489017M #HL25489020C/#HL25489019M On February 3, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 5 clients receiving services under the provider's Comprehensive license. The following correction orders are issued for HL25489018C/HL25489017M and HL25489020C/HL25489019M, tag identification: 0305, 0320. The following correction orders are issued for HL25489018C/HL25489017M 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).	

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0 305	Continued From page 1	0 305		
0 305 SS=D	144A.44, Subd. 1(a)(10) Information Private 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: (10) have personal, financial, and medical information kept private, and to be advised of the provider's policies and procedures regarding disclosure of such information; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that medical information was kept private for two of three clients, C2 and C3, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation had occurred only occasionally). The findings include: C2 was admitted on June 22, 2021 with diagnoses including Migraine. C2's nursing assessment dated October 19, 2021, indicated C2 did not take medications, used a wheelchair for mobility and needed some assistance with dressing. C2's service plan dated July 6, 2021, indicated C2 needed daily assistance with	0 305		

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0 305	Continued From page 2 dressing, light housekeeping, and vital signs and monitoring daily for withdrawal and isolation. C3 was admitted on March 17, 2017 with diagnoses including cerebral palsy and bipolar disorder. C3's nursing assessment dated, November 24, 2021, indicated C3 needed assistance from staff with dressing the lower extremities. C3's service plan dated, August 1, 2018, indicated C3 needed daily staff assistance with eating, light housekeeping, equipment cleaning, and transfers. A facility incident report dated, December 11, 2021, indicated C2 was outside the staff office door and could hear staff doing shift report. During interview on March 18, 2022, at 10:07 a.m., registered nurse (RN)-D stated when staff did report it was done in the staff office and there was a door that could be closed for privacy. RN-D stated sometimes staff would just give report in passing. During an interview on March 18, 2022, at 11:51 a.m., unlicensed personnel (ULP)-E stated one winter day in 2021, date unknown, ULP-B and ULP-E had been giving a verbal report in the staff office with the door open and C2 overheard report about himself and had gotten offended. ULP-E stated she informed the house manager of the incident who told ULP-E to keep the staff office door closed during report. During interview on March 22, 2022, at 5:32 p.m., C3 stated she can hear staff in the office; especially in the morning. C3 stated she had told staff that she could hear them talking. The facility policy titled Training and Competency	0 305		

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0 305	Continued From page 3 Evaluation dated October 25, 2018, indicated all ULP's will complete training and competency requirements in several areas including: (l) confidentiality and privacy. The licensee's service plan form indicated a privacy notice to all clients specified that personal, financial, and medical information would be kept private and released only with the client's permission or the of a representative. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 305		
0 320 SS=E	144A.44, Subd. 1(a)(13) Treated With Respect 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: (13) be treated with courtesy and respect, and to have the client's property treated with respect; This MN Requirement is not met as evidenced by: Based on interviews and record review, the facility failed to ensure clients were treated with dignity and respect for 3 of 3 clients, C1, C2, and C3, reviewed who had complaints about staff treatment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 320		

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0 320	Continued From page 4 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation had occurred repeatedly; but is not found to be pervasive). Findings Include: C1 was admitted on March 1, 2017, with the diagnoses including post-polio syndrome and breathing issues. C1's nursing assessment dated November 24, 2021, indicated C1 used a mechanical lift, bedpan, and had a back brace. C1 required staff assistance with bathing, dressing, grooming, transfers, eating and bed mobility. C2 was admitted on June 22, 2021 with the diagnoses of Charcot Marie Toothe (nerve disease) and Migraine. C2's nursing assessment dated October 19, 2021, indicated C2 did not take medications, used a wheelchair for mobility, and needed some assistance with dressing. C2's service plan dated July 6, 2021, indicated C2 needed daily assistance with dressing, light housekeeping, vital signs, and monitoring for withdrawal and isolation. C3 was admitted on March 17, 2017 with the diagnoses of cerebral palsy and bipolar disorder. C3's nursing assessment dated November 24, 2021, indicated C3 needed assistance from staff with dressing lower extremities. The facility provided a Snap Message dated December 15, 2021 at 10:02 p.m., which indicated C3 believed that unlicensed personnel (ULP)-B killed C3's cat. This same document indicated ULP-B was "curt" (blunt, short, abrupt) with the resident.	0 320		

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0 320	Continued From page 5 A facility incident report dated December 17, 2021 at 9:25 a.m., indicated C1 reported to ULP-A she was upset because she put her call light on several times and ULP-B came to C1's room and yelled: "It's not your time yet"! C1 also reported ULP-B was talking on the telephone to an unknown person and was saying a bunch of "nasty things" about C1. The facility investigation completed by the administrator (ADM)-C on December 17, 2021, indicated ULP-A reported the following concerns regarding ULP-B: - C1 turned on her call light for assistance with toileting and ULP-B responded. ULP-B told C1 she could not have the bedpan because it was not her time yet and someone was in the bathroom where the bedpan was located. - ULP-B told C1 she wished C1 would get sick and die, that C1 is too fat, too heavy, and C1 should be in a nursing home. - ULP-A heard ULP-B tell C3 that she smelled like urine. The facility investigation dated December 17, 2021, also indicated C1 stated ULP-B said hurtful comments such as, I hate you, and I hope you end up in bed next to a client that had previously passed away from COVID-19. During interview on March 16, 2022 at 11:33 a.m., ADM-C stated she received a text from ULP-A that he had concerns regarding another staff member's behavior toward C1. ADM-C stated C1 told ULP-A that ULP-B had refused to give C1 the bedpan. During interview on March 17, 2022 at 1:10 p.m., C2 stated his first month at the facility was	0 320		

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0 320	Continued From page 6	0 320		

challenging and draining when ULP-B would assist him with cares. C2 stated the facility seemed quieter and more calm now that ULP-B does not work there. C2 stated he heard ULP-B arguing with C3, using the "BS" [bullshit] word, and called C3 crazy. C2 stated C3 told her she did not like ULP-B putting her underwear on in front of other residents. C2 stated he had observed ULP-B put C3's underwear on in the community room and kitchen areas of the licensee but was not able to recall the dates this occurred. C2 also stated ULP-B threatened to report him and closed a door on him, C2 then attempted to open the door and ULP-B closed the door again and it hit the foot plate of his wheelchair.

During interview dated March 17, 2022 at 2:15 p.m., ULP-A stated C1 told him ULP-B had been intimidating the client for several months and C1 stated they were very upset by this. C1 told ULP-A that ULP-B told the client that she hopes she gets sick and dies in the hospital. ULP-A stated C1 started to cry when she told him about this statement.

During interview on March 18, 2022 at 10:07 a.m., registered nurse (RN)-D stated C3 blamed ULP-B for her cat dying.

During interview on March 18, 2022 at 11:51 a.m., ULP-E stated her and ULP-B were giving each other a shift report in the staff office and C2 overheard the information. ULP-B got up and shut the door.

During interview on March 21, 2022 at 2:02 p.m., C1 stated ULP-B said hurtful things to C1 in the past such as I hate you and I hope you end up I the hospital next to a past client who had recently

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0 320	Continued From page 7 died of COVID-19. C1 stated she does not know why ULP-B said that to her and she did not respond to ULP-B after the comment. During interview on March 21, 2022 at 5:32 p.m., C3 stated a staff member let her cat out of the facility and the cat got run over. C3 stated she overheard the same staff member who let the cat out laughing and said at least "we" got rid of the cat. C3 also stated a staff member was sleeping on the couch and C3 had to bring her clothes and undergarments out to the community room so the staff member could assist the client. The staff member assisted C3 with getting dressed in the public community room. C3 did not want to state the name of the staff member, however, confirmed that the staff member was the same person in both of the scenarios mentioned in the interview. The facility policy titled Training and Competency dated, October 18, 2018, indicated, (k) Communication skill that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family. (l) confidentiality and privacy and (s) Recognizing physical, emotional, cognitive, and developmental needs of the client. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 320		
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 8 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 interviews and document review, the facility failed to ensure one of three clients reviewed (C1) was free from maltreatment. C1 was abused. Findings include: On February 3, 2022, the Minnesota Department of Health (MDH) issued a determination that abuse occurred for C1, and that an individual 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.	