Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL26626008M
Compliance #: HL26626009C

Date Concluded: October 12, 2020

Name, Address, and County of Licensee Investigated:
Walker Methodist Highview Hill
20150 Highview Avenue
Lakeville, MN 55044
Dakota County

Facility Type: Home Care Provider

Investigator's Name:
Shannan Stoltz, RN Special Investigator
Paul Spencer, 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), an unlicensed personnel staff member, abused the client when the AP gave the client a shower against C1's will.

Investigative Findings and Conclusion:
Abuse was substantiated. The AP treated the client in a manner that was humiliating, harassing, and threatening, when the AP disrobed the client and physically forced the client into a shower, against the client's expressed wishes. The AP proceeded to shower the client while the client was physically and verbally resisting, causing distress to the client. The AP was responsible for the maltreatment.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation also included an onsite visit for observations, review of medical records, and review of facility policies and procedures.

The client's medical record was reviewed. The client's medical diagnoses included unspecified dementia with behavioral disturbance, history of falling, and difficulty in walking. The client's signed service plan indicated the client received medication management, assistance of one with personal cares and dressing, and twice-weekly showers scheduled for dayshift hours.

On the day of the incident, dayshift staff gave the client a shower in the morning hours without contention. Later that day during the afternoon shift, the AP requested a different staff member to assist the AP to shower the client. The AP stated the client emanated a foul odor and needed a shower.

During an interview with an unlicensed staff member, she stated that the AP had remarked the client would receive a shower that evening, even if the AP had to wrestle the client into the shower. This same staff member also stated the following incident occurred: both AP and staff member entered the client's room. The AP asked the client if she wanted to shower, and the client stated she did not. After AP, the staff member, and the client walked into the bathroom, the AP closed and locked the bathroom door, and told the client she needed to take a shower because she smelled badly. The client stepped towards the door and yelled "NO!" and "Get out of my way". The AP blocked the door with her body and the client was unable to leave the bathroom. The staff member further stated that while AP faced the client at the door, AP put her arms around the client and ripped the client's shirt off over her head. The client then yelled at AP to get out of her room and to not touch her. The AP pulled the client's pants down, wrapped her arms around the client, and picked the client up. The AP then carried the client into the shower, where she sprayed the client with the shower hose. During the shower, the client punched and kicked at AP, and screamed the following things: help me, stop, no, I don't want to take a shower, don't touch me, get out of my room, and someone call the police. The staff member stated that after the shower was completed, AP left the client's room and the staff member assisted the client to get dressed. The client asked the staff member how to file a report and the staff member told the client she (staff) would report the incident to management.

During an interview, the executive director stated she interviewed the client one day after the shower incident, and the client was still distressed. The executive director also stated the client verbalized she was afraid, felt unsafe, and thought someone was going to hurt her. The executive director stated she interviewed the AP via telephone about the shower incident, and the AP stated she was able to get the client showered, but would not clarify how she (AP) had physically accomplished it. The executive director suspended, and then terminated AP's employment.

During an interview, the resident service manager stated she had interviewed the client two days after the incident, and the client was still upset. The resident service manager also stated the client verbalized that she had yelled for help, had been afraid she would be beaten up, and twice stated that her clothes were ripped off her body. The resident service manager further stated that the client asked several times if she smelled badly, and appeared to ruminate about being told she smelled.

During an interview, a dayshift staff member stated she gave the client a shower on the morning of the incident, and the client was compliant. She said the client's showers were care-planned for Monday and Thursday mornings. The staff member also stated that the day after the incident, the client

spontaneously stated that she was abused during the prior evenings shower, a person had blocked the bathroom door so she could not escape, and that she wanted to report it. This staff member further stated that the client did not smell badly during the incident period, and is now afraid to shower.

In conclusion, 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;
(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; cognitive deficit
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No; did not return phone calls

Action taken by facility: AP's employment was terminated

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
Dakota County Attorney
Lakeville City Attorney
Lakeville Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H26626	A. BUILDING: _____ B. WING _____	C 09/29/2020

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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: On September 29, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL26626008M/#HL26626009C. At the time of the investigation, there were 97 clients receiving services under the comprehensive license. The following correction order are issued for #HL26626008M/#HL26626009C, tag identification 280, 0325, and 0810.	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).	
0 280 SS=G	144A.44, Subd. 1(a)(5) Right to Refuse Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or	0 280		

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0 280	Continued From page 1 in an assisted living facility licensed under chapter 144G has these rights: (5) refuse services or treatment; This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to protect a client's right to refuse services or treatment, for 1 of 1 clients reviewed, when staff forced client #1 (C1) to bathe against her will. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and is 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 has occurred only occasionally). Findings include: C1's medical record was reviewed. C1's medical diagnoses included unspecified dementia with behavioral disturbance, history of falling, and difficulty in walking. C1's signed service plan indicated C1 received medication management, and assistance of one with personal cares and dressing. C1's service plan dated July 30, 2020, indicated C1 received twice-weekly assistance with showering, every Monday and Thursday morning. The service plan also instructs staff to "postpone care and re-approach if resident's refusal or agitation persists".	0 280		

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0 280	Continued From page 2 C1's Service Received dated June 18, 2020, at 8:00 am, indicated C1 took a shower with the assistance of one. C1's Service Received dated June 18, 2020, at 10:49 pm, indicated C1 took a shower with the assistance of one. During an interview on September 29, 2020, at 11:39 a.m., unlicensed personnel (ULP)-B stated that on June 18, 2020, during the evening hours, unlicensed personnel (ULP)-A requested ULP-B's assistance to shower C1. ULP-B also stated ULP-A said C1 would receive a shower that evening, even if ULP-A had to wrestle her (C1) into the shower. ULP-B further stated the following incident occurred: both ULP's entered C1's room and ULP-A asked C1 if she wanted to shower. C1 stated she did not. After ULP-A, ULP-B, and C1 walked into the bathroom, ULP-A closed and locked the bathroom door, and stated that C1 needed to take a shower because she (C1) smelled badly. C1 stepped towards the door and yelled "NO!" and "Get out of my way." ULP-A blocked the door with her body and C1 was unable to leave the bathroom. ULP-B stated ULP-A faced C1 at the door, ULP-A put her arms around C1 and ripped C1's shirt off over her head. C1 then yelled at ULP-A to get out of her (C1's) room and to not touch her. ULP-A pulled C1's pants down, wrapped her arms around C1, and picked C1 up. ULP-A then carried C1 into the shower, where she sprayed C1 with the shower hose. During the shower, C1 punched and kicked at ULP-A, and screamed the following things: help me, stop, no, I don't want to take a shower, don't touch me, get out of my room, and someone call the police. ULP-B further stated that after the shower was completed, ULP-A left C1's room and ULP-B assisted C1 to get dressed. C1	0 280		

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0 280	Continued From page 3 asked ULP-B how to file a report and ULP-B stated she would report the incident to management. During an interview on September 29, 2020, at 12:18 pm, resident service manager (RSM)-E stated she interviewed C1 on Saturday, June 20, 2020 (two days after the shower incident), and C1 was still upset. RSM-E also stated C1 verbalized that she had yelled for help, had been afraid she would be beaten up, and twice stated that her clothes had been ripped off her body. RSM-E further stated that C1 asked several times if she (C1) smelled badly, and that C1 appeared to ruminate on being told she (C1) smelled badly. During an interview on September 29, 2020, at 2:47 pm, executive director (ED)-D stated she interviewed C1 on June 19, 2020 (one day after the shower incident), and C1 appeared to still be distressed. ED-D also stated C1 verbalized she felt afraid, unsafe, and that someone was going to hurt her. During this same interview, the ED-D stated she interviewed ULP-A on June 19, 2020, via a telephone call, about C1's shower incident. Per the ED-D's statement, ULP-A repeatedly stated she was able to get C1 showered, and that she had "gotten it done," but would not clarify how she (ULP-A) physically accomplished getting C1 into the shower. ED-D further stated that during this phone call, she suspended ULP-A until further notice. During an interview on October 1, 2020, at 3:15 pm, unlicensed personnel (ULP)-G stated she worked dayshift on June 18, 2020, gave C1 a shower without incident, and that C1's showers were scheduled to be completed during the AM hours, on dayshifts. ULP-G also stated that on June 19, 2020, C1 spontaneously stated that she	0 280		

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0 280	Continued From page 4 was abused during the prior evenings shower, a person had blocked the bathroom door so she (C1) could not escape, and that she (C1) wanted to report it. ULP-G further stated that C1 did not smell badly during the incident period, and since the incident C1 is now afraid to shower. On October 2, 2020, and October 5, 2020, voice messages were left on ULP-A's voicemail, but ULP-A did not return a call. Facility provided document Investigative Summary, undated, indicated ED-D interviewed C1, ULP-A, and ULP-B the day after the shower occurrence. This facility investigative packet notated C1's statement as, "Resident reported that a large woman forcibly removed her clothing, then confined her to her shower, and proceeded to forcibly bathe her." This packet included a transcript of ED-D's and ULP-A's phone call which indicated ED-D asked ULP-A how C1 got undressed, and if C1 had walked into the shower of her own accord. The transcript notated ULP-A stated, "I wouldn't have pushed her as far to do it if she didn't stink as bad as she did", and "We had to definitely nudge her in". The investigative packet indicated the facility suspended ULP-A on June 19, 2020, and terminated ULP-A on June 22, 2020. Facility provided document of ULP-A's training dated March 12, 2018, indicated ULP-A reviewed the section of compliance with, and reporting of, maltreatment of vulnerable adults. This same document further indicated ULP-A reviewed preserving the dignity of residents, respect for resident's preferences, and recognizing the emotional needs of resident's. Facility provided document titled Townhall	0 280		

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0 280	Continued From page 5 Meeting Agenda dated January 2018, indicated training/discussion on communication for clients with dementia. This same document indicated unlicensed personnel ULP-A signed and dated on July 31, 2019, at 4:30 pm, signifying her presence during this training/discussion session. Facility provided document titled Townhall Meeting Agenda dated July 2019, indicated training/discussion on effective communication for clients with dementia. This same document indicated unlicensed personnel ULP-A signed and dated on August 1, 2019, at 4:30 pm, signifying her presence during this training/discussion session. Facility provided policy titled Vulnerable Adult Maltreatment Prevention and Reporting - Housing Administration dated January 7, 2019, indicated the facility promotes the right of each resident to be free from abuse. This Policy further indicated the facility's terminology of abuse is the willful infliction of unreasonable confinement, intimidation, or mental anguish. On this same policy, the facility's definition of 'willful' indicated the "individual must have acted deliberately". TIME PERIOD FOR CORRECTION: IMMEDIATE	0 280		
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: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of	0 325		

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0 325	Continued From page 6 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 97 clients reviewed (C1) was free from maltreatment. C1 was abused. Findings include: On September 29, 2020, 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 maltreatment public report for details.	
0 810 SS=D	144A.479, Subd. 6(b) Individual Abuse Prevention Plan (b) Each home care provider must develop and implement an individual abuse prevention plan for each vulnerable minor or adult for whom home care services are provided by a home care provider. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults	0 810		

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0 810	Continued From page 7 or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to develop and implement an individual abuse prevention plan for a vulnerable adult, for 1 of 1 client reviewed. Client #1's (C1) service plan indicated C1 is a vulnerable adult, but the licensee failed to address specific measures to minimize C1's risk of abuse to self, to others, or by others. The licensee also failed to ensure C1's medical record included a statement that indicated specific measures to minimize C1's risk of abuse. 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) 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 has occurred only occasionally). The findings include: C1's medical record was reviewed. C1's medical diagnoses included unspecified dementia with behavioral disturbance, history of falling, and difficulty in walking. C1's signed service plan indicated C1 received medication management, and assistance of one with personal cares and dressing. C1's service plan dated July 30, 2020, indicated C1 "is a vulnerable adult and is at risk from others", but does not specify what type of risk. C1's service plan did not contain specific	0 810		

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0 810	Continued From page 8 measures to mitigate C1's risk of physical abuse, sexual abuse, or financial exploitation. In addition, the service plan stated C1 may be a risk to others, but did not describe any such risk or include any interventions to mitigate that risk. C1's Individual Abuse Prevention Plan (IAPP) was requested from facility, but not received. In an email from the facility's director of nursing (DON)-F dated October 1, 2020, at 2:17 pm, she indicated their facility does not have a stand-alone IAPP for any client's, but instead their abuse prevention plan is incorporated into all client's service plans. Facility provided policy titled Vulnerable Adult Maltreatment Prevention and Reporting - Housing Administration dated January 7, 2019, indicated each resident who receives services would have an individual abuse prevention plan and an individualized assessment of a resident's susceptibility of abuse to self, to others, or by others. The policy further indicated a statement be included outlining the specific measures to take to minimize the risk of abuse for resident's. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		