Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL35671005M
Compliance #: HL35671006C

Date Concluded: April 30, 2021

Name, Address, and County of Licensee Investigated:
Metro Care Human Services
6043 Hudson Road, Suite 340
Woodbury, MN 55125
Washington County

Name, Address, and County of Housing with Services location:
Metro Care Human Services
1214 3rd Street Northeast
Minneapolis, MN 55413
Hennepin County

Facility Type: Home Care Provider

Investigator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, facility and 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) verbally abused the client, and physically abused the client, when the AP slapped the client knocking a phone out of the client's hand. It is also alleged an unknown AP financially exploited a client when the unknown AP stole money and belongings from the client's room.

Investigative Findings and Conclusion:

Physical abuse was substantiated. The AP was observed on video slapping the client. The AP admitted to slapping the client. The facility failed to provide staff training to properly and effectively implement behavior plan interventions.

Financial exploitation was inconclusive. The client did not want to discuss concerns regarding missing money or items with the facility or outside investigative agency(s). The facility paid the client the amounts of his alleged losses and worked with the client's case manager to create an inventory of the client's belongings.

Verbal abuse was not substantiated. The AP raised her voice during an altercation with the client and used swear words; however, the incident did not meet the definition of verbal abuse.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. The investigator reviewed a police report and interviewed another client at the facility. A video of the interaction between the AP and the client on the night of the incident was reviewed. The investigator toured the facility, observed staff/client interactions, reviewed client records, staff personnel records, facility incident report documentation, and policies related to maltreatment, supervision of staff, orientation of staff, adverse events, and unsafe homecare situations.

The client lived at the facility for several months due to diagnoses including schizophrenia and antisocial personality disorder. The client received services from the home care provider that included medication administration, homemaking, shopping, assistance with appointments, transportation, meal preparation, and behavior management. The client shared an apartment with another client who received services, and each had their own private bedroom.

On the evening of the incident, the AP knocked on the clients' apartment door. The AP did not hear a response, so let herself into the apartment with her work key. When the AP entered the apartment, the client yelled at the AP to not come in without permission. The AP yelled back at the client, who began recording the incident on his cell phone. The AP and the client continued to argue, and the AP slapped the client's hand.

Review of the video indicated the AP yelled at the client about having the interaction recorded, repeatedly told the client that she did not have to ask permission, told the client that he was too close to her, and told the client to get out of her way. The AP continued to argue and yell at the client, told the client that he needed to move, and as he moved behind the AP, she screamed at the client to not get behind her, swore at the client, pulled her arm back, and slapped the client. The slap knocked the phone out of the client's hand.

When interviewed the program manager stated the client called him on the night of the incident, frustrated that the AP used her key to come into his apartment without permission. The program manager found out about the video the next day and reviewed it. The program

manager identified that it was the AP who slapped the client in the video and said it was unacceptable behavior. The program manager said the AP received vulnerable adult training in orientation. The program manager said all staff receive online education about mental health, but there was no verification of completion or understanding. The program manager said specific interventions for staff were in the client's behavior plan, but he had no documentation that staff reviewed the interventions.

During an interview, a staff said that she was trained to either engage or disengage with clients when they had behaviors. The staff said that she used the same techniques with all clients and was not familiar with specific behavior interventions for specific clients.

During interview the AP stated on the night of the incident she wanted to come into the apartment to give the client's roommate his medication. The AP said she knocked on the door before she entered the apartment. The AP said that the client kept saying the same thing over and over that she could not come on his property. The AP said that she felt the client had a problem with her. The AP denied that she raised her voice at the client. The AP said that the client stood in her way, preventing her from leaving and when he got behind her it scared her and she "just snapped and slapped him". The AP said that she did not feel that she received adequate training and did not understand how the clients could just go out and be on their own, but staff had to give them their medication and clean for them.

The client did not want to discuss the slapping incident or any concerns with missing personal items/money. The client said he was happy living at the facility.

In conclusion, physical abuse was substantiated, financial exploitation was inconclusive, and verbal abuse was not 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;
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.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: N/A
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The AP no longer works at 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, or call 651-201-4201 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
Hennepin County Attorney
Minneapolis City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H35671	A. BUILDING: _____ B. WING _____	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO CARE HUMAN SERVICES	6043 HUDSON ROAD STE 340 WOODBURY, MN 55125

(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 April 29, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL35671006C/#HL35671005M. At the time of the survey, there were #6 clients receiving services under the comprehensive license. The following correction orders are issued for #HL35671006C/#HL35671005M, tag identification _0325, 1180, and 1225	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 surveyors' 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 follow-up surveys. 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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0 325	Continued From page 1	0 325		
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 maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: On April 29, 2021, the Minnesota Department of Health (MDH) issued a determination that abuse occurred to client #1, and that the facility and 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) is required. Please refer to the public maltreatment report for details.	
01180 SS=F	144A.4796, Subd. 4 Orientation to Client Subd. 4.Orientation to client. Staff providing home care services must be oriented specifically to each individual client and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to provide orientation specific to	01180		

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01180	Continued From page 2 one of one clients (C1) reviewed when unlicensed personnel (ULP)-F was observed on video screaming at C1, yelling that she did not have to ask him anything, refusing to leave the area, and slapping C1. The actions of ULP-F were contrary to C1's behavior plan and ULP-F's personnel file had no documentation of staff orientation to C1. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). Findings include: C1 moved into the facility on December 28, 2020 due to diagnoses that included schizophrenia, borderline intellectual disability, hypertension, and antisocial personality disorder. C1's service plan dated December 28, 2020 indicated C1 received services from the home care provider that included medication administration and a behavior support plan. C1's Home Health Aide Care Plan dated January 11, 2021 indicated unlicensed personnel interventions for C1 included medication administration, vital signs, weight, and "BSP" (behavior support plan). C1's Behavior Plan dated January 4, 2021 indicated C1's target behaviors included paranoia, psychosis, and irritability. C1's plan indicated C1 could be verbally/physically intimidating and easily triggered due to past	01180		

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01180	Continued From page 3 trauma. C1's plan directed staff with interventions that included treating C1 with dignity and respect, deescalating situations by talking with C1 at a later time, speaking with C1 in a calm tone of voice, and asking C1 for cooperation rather than telling C1. C1's behavior plan indicated all staff were trained in general behavior management, trained on individual care plans, trained on behavior care plans, and staff received additional training as needed. Review of undated video provided by C1 showed unlicensed personal (ULP)-F engaging in a verbal argument with C1. In the video ULP-F is heard yelling at C1 "I don't have to ask you nothing! I don't have to ask you anything! You do not work here! Stop recording me! Get out of my way! I don't have to get out of nothing! You are interfering with a client! You are not the only one here! Get out my way! Get out my way! "The video ended with ULP-F slapping C1's hand holding the phone. During an interview on April 29, 2021 at 10:15 a.m. unlicensed personnel (ULP)-D stated she was trained to engage or disengage with clients when they had behaviors. ULP-D stated that meant she either stayed and talked with the client or walked away and talked to the client later. ULP-D stated she used the same techniques with all clients. During an interview on April 29, 2021 at 11:50 a.m. program manager (PM)-B confirmed that C1's mental health care plan indicated that all direct care staff received general behavior management training and mental health care plan training specific to each individual client. PM-B confirmed the facility had no documentation of general behavior management training, mental	01180		

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01180	Continued From page 4 health care plan training, or behavior plan training for ULP-F specific to C1 or any other clients. PM-B verified that he received a copy of the video provided by C1 and that it had been taken on March 18, 2021 during the conflict between C1 and ULP-F. During an interview on Aril 29, 2021 at 1:30 p.m. registered nurse (RN)-C confirmed there was no documentation of staff orientation to C1. The Staff Orientation and Education policy dated April 5, 2020 indicated all staff providing home health care will be prepared to provide safe, effective services to all clients through a thorough orientation and education program pertinent to the needs of the clientele. The policy further indicated direct care staff received specific orientation to each individual client's services and that proof of education was maintained in personnel files. TIME PERIOD FOR CORRECTION: Seven (7) days	01180		
01225 SS=F	144A.4797, Subd. 3 Supervision of Staff - Comp Subd. 3.Supervision of staff providing delegated nursing or therapy home care tasks. (a) Staff who perform delegated nursing or therapy home care tasks must be supervised by an appropriate licensed health professional or a registered nurse periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered	01225		

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01225	Continued From page 5 nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the client. (b) The direct supervision of staff performing delegated tasks must be provided within 30 days after the date on which the individual begins working for the home care provider and first performs delegated tasks for clients and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to conduct supervision of unlicensed personnel (ULP) providing delegated nursing tasks for one of one staff (ULP-F) whose personnel file was reviewed. The registered nurse did not conduct supervision of any unlicensed personnel employed by the licensee. 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 a widespread scope. (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). Findings include: The licensee hired ULP-F on August 25, 2020 to provide direct care services for clients. ULP-F's personnel file indicated ULP-F received medication management training by registered	01225		

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01225	Continued From page 6 nurse (RN)-C on August 25, 2020. ULP-F's Employee Corrective Action form dated January 7, 2021 indicated ULP-F received a written warning for failure to follow the medication administration policy when ULP-F left a client's medications unsecured at the client's bedside. ULP-F's personnel file did not contain documentation of supervision of delegated nursing tasks. C1's record was reviewed. C1 moved into the facility on December 28, 2020 due to diagnoses that included schizophrenia, borderline intellectual disability, hypertension, and antisocial personality disorder. C1's service plan dated December 28, 2020 indicated C1 received services from the home care provider that included medication administration. C1's medication administration record indicated ULP-F administered medication to C1 on March 8, 2021. C3's record was reviewed. C3 moved into the facility on February 15, 2021 due to diagnoses that included depression, anxiety, and post-traumatic stress disorder. C3's service plan dated February 15, 2021 indicated C3 received service from the home care provider that included medication administration. C3's medication administration record indicated ULP-F administered medication to C3 on March 2, 3, 4, 5, 6, 7, and 8, 2021. During an interview on Aril 29, 2021 at 1:30 p.m.	01225		

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01225	Continued From page 7 registered nurse (RN)-C confirmed there was no documentation of 30-day supervision of ULP-F. RN-C indicated that she conducted a "30-day audit of new employee personnel files" but did not know what supervision of staff performing delegated nursing tasks entailed. RN-C stated that as the only nurse, she supervised all unlicensed personnel at the licensee's locations. RN-C confirmed the licensee's policy indicated that a registered nurse shall conduct 30-day supervision of unlicensed personnel performing delegated tasks. The Supervision-Comprehensive Services policy dated April 5, 2020 indicated home health aides (unlicensed personnel) providing services to home health clients would be supervised to assure that the work was being performed competently and to identify problems and solutions to address issues related to the employee's ability to provide services to clients. The policy further indicated the registered nurse provided supervision within 30 days after the individual provided delegated tasks. TIME PERIOD FOR CORRECTION: Seven (7) days	01225		