Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Madonna Meadows	HL20566006	August 29, 2017
Facility Address:	**Time of Visit:**	**Date Concluded:**
3035 Salem Meadows Drive SW	10:00 a.m. to 3:00 p.m.	September 16, 2017
Facility City:	**Investigator's Name and Title:**	
Rochester	Meghan Schulz, RN, Special Investigator	

State:	ZIP:	County:
Minnesota	55902	Olmsted

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was abused when staff/alleged perpetrator posted a picture of the client on social media with a description of "This little shit just pulled the fire alarm and now I have to call 911."

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, abuse is substantiated. The alleged perpetrator (AP) posted a humiliating picture of the client on two social media sites with derogatory language.

The client received services from a provider licensed as a comprehensive home care provider. The client had a diagnosis of Alzheimer's dementia and received toileting, grooming, and medication management services.

A staff member brought a picture on social media to the attention of facility management. The AP is standing in the picture using her cell phone to take a picture of him/herself and the client in the mirror. The client is sitting in a chair in the background, with his/her face and body visible. The words "This little shit just pulled the fire alarm and now I had to call 911!!! woohoo" are present on the picture.

The picture of the client in question was obtained and reviewed during the investigation.

During an interview, the client revealed s/he did not recall the incident.

During an interview, the family said, if the client did not have a memory impairment and was able to recall

the incident, s/he would be upset by the picture.

During an interview, the AP admitted to posting the picture of the client on social media. The AP admitted to using the derogatory language and stated s/he took the picture of the client and posted it, because s/he thought it was funny.

During an interview, management stated the facility responded immediately by instructing the AP to delete the picture from social media and suspended the AP pending an internal investigation. The AP was terminated after the investigation. Management retrained all facility staff on patient privacy and cell phone use.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☒ Abuse ☐ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☐ Facility is responsible for the

☒ Abuse ☐ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility had policies policies and education in place to address abuse, cell phone use, social media use, and patient privacy. The AP's personnel files showed the AP's acknowledgment of receiving the "Employee Handbook" where the policies were located, as well as documentation of training and education.

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.

Compliance:

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not

met.

State licensing orders were issued: [x] Yes [ ] No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: [x] Yes [ ] No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 2 - Abuse

"Abuse" means:

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.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Nurses Notes
- [x] Assessments
- [x] Facility Incident Reports
- [x] Service Plan

Other pertinent medical records:

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: none identified

Were residents selected based on the allegation(s)? ○ Yes ○ No ◉ N/A

Specify:

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A

Specify:

Interviews: The following interviews were conducted during the investigation:

Interview with reporter(s) ◉ Yes ○ No ○ N/A

Specify:

If unable to contact reporter, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify:

Did you interview the resident(s) identified in allegation:

(●) Yes ( ) No ( ) N/A Specify: ____________________

Did you interview additional residents? (●) Yes ( ) No

Total number of resident interviews:five

Interview with staff: (●) Yes ( ) No ( ) N/A Specify: ____________________

Tennessen Warnings

Tennessen Warning given as required: (●) Yes ( ) No

Total number of staff interviews: six

Physician Interviewed: ( ) Yes (●) No

Nurse Practitioner Interviewed: ( ) Yes (●) No

Physician Assistant Interviewed: ( ) Yes (●) No

Interview with Alleged Perpetrator(s): (●) Yes ( ) No ( ) N/A Specify: ____________________

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ( ) Yes, date subpoena was issued __________ ( ) No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify __________

Observations were conducted related to:

☒ Personal Care

☒ Nursing Services

☒ Call Light

☒ Infection Control

☒ Cleanliness

☒ Dignity/Privacy Issues

☒ Safety Issues

☒ Transfers

☒ Facility Tour

☒ Incontinence

Was any involved equipment inspected: ( ) Yes ( ) No (●) N/A

Was equipment being operated in safe manner: ( ) Yes ( ) No (●) N/A

Were photographs taken: ○ Yes ◉ No Specify: ______________________

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Olmsted County Attorney

Olmsted County Sheriff

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20566	A. BUILDING: ______ B. WING ______	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA MEADOWS	3035 SALEM MEADOWS DRIVE SW ROCHESTER, MN 55902

(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, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On August 29. 2017, a complaint investigation was initiated to investigate complaint #HL20566006. At the time of the survey, there were 21 clients that were receiving services under the comprehensive license. The following correction order is issued.	0 000	*****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.	
0 325 SS=D	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to 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 document review and interview, the	0 325		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Minnesota Department of Health

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0 325	Continued From page 1 licensee failed to ensure the right of one of one client (C1) reviewed to be free from maltreatment when a staff member abused the client when the staff member posted a humiliating picture of C1 on two social media sites with derogatory language. The violation occurred as 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 that a situation has occurred only occasionally). The findings include: C1's record was reviewed. C1 received services from a provider licensed as a comprehensive home care provider. The client resided in the memory care unit and had a diagnosis of Alzheimer's dementia and received toileting, grooming, and medication management services. The picture of the client in question was requested and reviewed on the date of the onsite investigation on August 29, 2017. The alleged perpetrator (AP-D) is standing in the picture using her cell phone to take a picture of herself and C1 in the mirror. C1 is sitting in a chair in the background, with her face and body visible. The words "This little shit just pulled the fire alarm and now I had to call 911!!! woohoo" are present on the picture. During an interview on August 29, 2017 at 11:20 a.m., C1 revealed s/he did not recall the incident. During an interview on August 29, 2017 at 12:15	0 325		

Minnesota Department of Health

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0 325	Continued From page 2	0 325		

p.m., the family (FM-C) said that if C1 did not have a memory impairment and was able to recall the incident s/he would be upset by the picture.

During an interview on August 30, 2017 at 1:36 p.m., unlicensed personnel (ULP-B) stated that s/he discovered the picture on the social media site on July 16, 2017 in the evening and notified the director or nursing (DON-A) on the morning of July 17, 2017.

During an interview on August 29, 2017, the director of nursing (DON-A) stated the picture was brought to his/her attention by unlicensed personnel (ULP-B). DON-A responded immediately by instructing the AP to delete the picture from social media and suspended the AP pending an internal investigation. The AP was terminated after the investigation. Management retrained all facility staff on patient privacy and cell phone use.

During an interview on August 30, 2017 at 2:02 p.m., AP-D admitted to posting the picture of the client on twitter and snap chat. The AP stated that she took the picture during her day shift on July 16, 2017 and posted it later that evening. The AP admitted to using the derogatory language and stated s/he took the picture of the client and posted it, because s/he thought it was funny. The AP stated that s/he was aware that cell phones and taking pictures of clients are prohibited.

TIME PERIOD OF CORRECTION: Twenty One (21) days