Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL22020005M
Compliance #: HL22020006C

Date Concluded: December 4, 2019

Name, Address, and County of Licensee Investigated:
The Shalom Home, LLC
2070 Century Hills Drive NE
Rochester, MN 55906
Olmsted County

Facility Type: Home Care Provider

Investigator's Name:
Amy Hyers, RN

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) physically and emotionally abused the client.

Investigative Findings and Conclusion:
Abuse was substantiated. The AP was responsible for the maltreatment. The AP grabbed the client's arm with force, towered over the client while yelling loudly, and treated her in a demeaning manner.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator toured the facility and made observations of clients. The investigation also included record review of the client's record, employee files, facility policies and procedures, incident reports, and a police report.

The client was admitted to the facility for diagnoses that included paranoid schizophrenia and Type 2 diabetes. She received comprehensive home care services that included assistance with

bathing; grooming and hygiene; dressing; incontinence cares; transfers; medication management; and daily blood sugar checks according to a service plan.

A witness observed the AP squeeze the client's left arm after the client declined incontinence cares. The witness further reported the AP "was in her (the client) face with both arm [sic] by the armrest blocking her to not escape." The witness stated the AP was singling the client out from the other clients and "shaming her for her bad behavior."

The witness alerted an off-duty staff member who instructed the witness to capture the incident with a photograph. The off-duty staff member immediately reported the abuse to the owner and nurse who immediately responded in-person to the facility. The owner also notified the police department. A police officer arrived at the facility shortly after the owner and nurse to conduct an investigation.

An internal investigation included a statement obtained from a fellow client who also witnessed the event. The statement indicated the client was ridiculing the AP and the AP told the client to "knock it off." The behavior continued and the AP pushed the client at the table and the client responded with "Ow!" The statement also depicted the AP put her face to the client's face, and the AP placed her right hand on the client's arm.

A police report included interviews with the witness, the AP, another client, and the abused client. The witness reported to the police officer that the AP scolded the client when the client declined using the restroom. The witness observed the AP squeezed the client's left arm because the AP was mad. While the AP scolded the client, she leaned over the client's chair and yelled just a few inches from the client's face; she held the armchair and the client could not go anywhere. When the witness was able to take the client to the restroom, the client said to her, "I don't deserve to be treated like this."

According to the police officer's interview with a fellow client, the witness asked her (fellow client) if the client could have some of this (fellow) client's candy. The (fellow) client said yes; however, the AP interjected and said no because the client had her own candy. The AP and the client engaged in an argument, and the AP got really close to the client's face. The (fellow) client thought the AP pushed the client as she heard the client say "Ow." The (fellow) client said the two argued twice. She said, "The AP is not real nice to the client."

The police officer's interview with the client included the following statements: "She pulled my arms (grabbing her left upper arm) when I was at the table. It was very demeaning. I will be very thankful if she (AP) is not here tomorrow." She told the officer she felt "abused verbally." The client also reported the AP had previously spat on and kicked her, but that had been "awhile back."

During the police officer's interview with the AP, she said the client often refused toileting with new staff. The AP stated that staff could not ask her if she wants to be toileted because she

would always say no. She further said the client always beat her (verbally) down; she tried to be nice to the client, but the client was nasty to her. The AP stated that the client "gets under my skin." The AP said she put her hand on the client's left wrist but did not squeeze, scratch, or anything. The AP stated that night the client got to her (the AP) again. When the client was at the table, the AP got close to her and tried explaining to her why she (client) needed to go to the toilet. The AP stated the distance was less than one foot.

A form in the AP's employee file indicated she had just received annual vulnerable adult training just 11 days before this event. Another form indicated the AP was terminated for physically abusing a client.

The witness stated she no longer wanted to discuss what happened and declined an interview.

During an interview, an off-duty staff member said she received a text from the witness who indicated she was uncomfortable with what she was observing. She said she did not like what the AP was doing to the client. The staff member said she asked the witness to take a picture with her cell phone and send it to her. The staff member said she then sent the information to the owner and the registered nurse.

During an interview, the registered nurse said she responded with the owner to the facility to investigate the situation. She said although she did not find any red marks or abrasions, the client was emotionally upset. She said the client told her the AP hit her and yelled at her. The registered nurse said another client said she saw the AP get in the client's face and yell at her. The registered nurse said the other clients were all kind of subdued and retreated to their individual rooms.

During an interview, the owner stated she received a text and picture of the AP leaning in close to the client's face. She said the text received from staff indicated the AP was shaming the client for not using the restroom. The staff also reported that the witness saw the AP squeeze the client's arm. The owner said when she arrived, the atmosphere in the facility was "...people were upset...they all retreated to their rooms that night." The client said it hurt right when it happened, but was pain-free at the time the owner spoke with her.

During an interview, the AP said she was training a new staff member the night of the incident. She said the client often refused cares for new people. The AP said she went over to the client to explain the need for incontinence cares. The AP said the client started arguing with her (like she often does). The AP stated the client "got in my face...she knew how to push my buttons." The AP said she got close to the client's face and got loud, but did not physically hurt her. The AP said she laid her hands on the client's wrist "but that was it." She further stated she said, "Liar, liar, pants on fire" to the client when she told the AP she did not need cares. The AP stated, "I shouldn't have said that." She repeated, "She just kept pushing my buttons."

In conclusion, abuse was substantiated. The AP squeezed the client's arm, yelled, and acted in a threatening and demeaning manner toward the client.

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: Yes.

Action taken by facility:
The AP is no longer employed by 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H22020	A. BUILDING: _____ B. WING _____	C 10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHALOM HOME LLC	2070 CENTURY HILLS DRIVE NE ROCHESTER, MN 55906

(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 October 16, 2019, the Minnesota Department of Health initiated an investigation of complaint #HL22020005M / HL22020006C. At the time of the survey, there were 7 clients receiving services under the comprehensive license. The following correction order is issued for #HL22020005M, 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 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).	
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	0 325		

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0 325	Continued From page 1 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 licensee failed to ensure the right of one of one client (C1) reviewed to be free from maltreatment when the (staff) alleged perpetrator (AP)-D grabbed C1's arm with force, towered over C1 while yelling loudly, and treated C1 in a demeaning manner in front of other clients. 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 was admitted to the facility on March 9, 2015, for diagnoses that included paranoid schizophrenia and Type 2 diabetes. C1 received comprehensive home care services to include assistance with bathing; grooming and hygiene; dressing; incontinence cares; transfers; medication management, and daily accuchecks according to a service plan dated April 12, 2019. Document review of a form titled, Record of Complaint, dated August 21, 2019, indicated unlicensed personnel (ULP)-B witnessed AP-D squeeze C1's left arm after C1 declined	0 325		

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0 325	Continued From page 2 assistance to use the restroom. The report further indicated AP-D "was in her (C1) face with both arm [sic] by the armrest blocking her to not escape." The report further indicated AP-D was singling C1 out from the other clients "shaming her for her bad behavior." The report depicted the other clients were "scared and afraid" of what was going to happen. Review of a picture taken during the incident revealed AP-D standing over C1 who was seated. AP-D had both chair arms gripped and was leaning in and over C1. C1 was leaning slightly back in the chair. The space between AP-D and C1's face appeared to measure approximately 8 inches. There were two other clients seated at the table with C1 observing the situation. A facility internal investigation report dated August 21, 2019, included a statement obtained from a client who witnessed the event. The statement indicated C1 was ridiculing AP-D, and AP-D told C1 to "knock it off." The behavior continued and AP-D pushed C1 at the table, and C1 responded with "Ow." The statement also depicted AP-D put her face to C1's face, and AP-D put her right hand on C1's arm. Document review of a Rochester Police Report for case #2019-00041377 depicted one count of abuse of vulnerable adult by caregiver; no violence. The responding police officer met with and interviewed the involved persons. Ownership staff (OW)-A responded immediately to the facility when she learned of the event at approximately 5:00 p.m. on August 21, 2019. She told the police officer that AP-D would be terminated for the safety of the clients. The police officer's interview with ULP-B included	0 325		

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0 325	Continued From page 3 the following statements: -She had been warned by other staff AP-D yells at clients. She was witness to the yelling during her first day of training (the event occurred on ULP-B's third day of training). -AP-D scolded C1 when C1 declined using the restroom to ULP-B. -AP-D squeezed C1's left arm because she (AP-D) was mad. -ULP-B took C1 to the restroom, and C1 said to her, "I don't deserve to be treated like this. She (AP-D) is a wicked woman and I've been putting up with this for many years now." -When AP-D scolded C1, she was leaning over C1's chair yelling just a few inches from C1's face. -AP-D held the armchair, and C1 could not go anywhere. -Another client appeared really scared about the situation. -The entire household seemed upset by the situation. The police officer's interview with AP-D included the following statements: -C1 often refused toileting with new staff. -You can't ask C1 if she wants to be toileted, she will always say no. -C1 always beats AP-D down. -She tries to be nice to C1, but C1 is nasty to her. -C1 gets under my skin. -AP-D tried telling C1 she is not allowed to refuse toileting. -AP-D did put her hand on C1's left wrist but did not squeeze or scratch or anything. -Tonight C1 got to her (AP-D) again. -When C1 was at the table, AP-D got close to her and tried explaining to her why she needed to go to the toilet. AP-D stated it was less than one foot distance.	0 325		

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0 325	Continued From page 4 The police officer's interview with C1 included the following statements: -"She pulled my arms (grabbing her left upper arm) when I was at the table." -"It was very demeaning." -"She's kicked me, she's spit on me...that was awhile back." -AP-D has told C1 she is an unworthy woman. -The situation made her feel "abused verbally." -"I will be very thankful if she (AP-D) is not here tomorrow." The police officer's interview with a fellow client included the following synopsis of the conversation: ULP-B asked the client if C1 could have some of the client's candy. The client said yes; however, AP-D interjected and said no because C1 has her own candy. AP-D and C1 engaged in an argument, and AP-D got really close to C1's face. The client thinks AP-D pushed C1 as she heard C1 say "ow." The client said the two argued twice. She said, "AP-D is not real nice to C1." Document review of AP-D's employee file included a form titled, Vulnerable Adult Annual Training, dated and signed by AP-D on August 10, 2019. Document review of a form titled, Employee Counseling, dated August 21, 2019, indicated AP-D was terminated for physically abusing a client. The form further indicated AP-D was given the opportunity to respond with a statement, but declined. An interview was attempted on November 14, 2019 at 2:29 p.m., with ULP-B. She stated she no longer wanted to discuss what happened and	0 325		

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0 325	Continued From page 5 declined an interview. During an interview on November 15, 2019 at 9:54 a.m., ULP-C said she received a text from ULP-B who indicated she was on her third day of training and was uncomfortable with what she was observing. She said she did not like what AP-D was doing to C1. ULP-C said she asked ULP-B to take a picture with her cell phone and send it to her. ULP-C then sent the information to OW-A and registered nurse (RN)-E. During an interview on November 15, 2019 at 1:16 p.m., RN-E said she responded with OW-A to the facility to investigate the situation. She said although she did not find any red marks or abrasions, C1 was emotionally upset. RN-E said C1 told her AP-D hit C1 and yelled at her. RN-E said another client said she saw AP-D get in C1's face and yell at her. She said the other clients were all kind of subdued and retreated to their individual rooms. During an interview on October 16, 2019 at 11:15 a.m., OW-A stated she received a text and picture of AP-D leaning in close to C1's face. She said the text received from ULP-C indicated AP-D was shaming C1 for not using the restroom. ULP-C also reported to OW-A that ULP-B witnessed AP-D squeeze C1's arm. OW-A said when she arrived, the atmosphere in the facility was"...people were upset...they all retreated to their rooms that night." OW-A alerted police to the incident and said a police officer arrived shortly after she did. OW-A said C1 said it hurt right when the incident with AP-D happened, but C1 was pain-free when OW-A spoke with her. During an interview on November 15, 2019 at 10:40 a.m., AP-D said she was training a new	0 325		

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0 325	Continued From page 6 staff member the night of the incident. AP-D said C1 often refused cares for new people. AP-D said she went over to C1 to explain the need for incontinence cares. AP-D said C1 started arguing with her (like she often does). AP-D said C1 "got in my face...she knew how to push my buttons." AP-D said she got close to C1's face and got loud, but did not physically hurt C1. AP-D said she laid her hands on C1's wrist "but that was it." AP-D also stated she said, "Liar, liar, pants on fire" to C1 when C1 told AP-D she did not need cares. AP-D did state, "I shouldn't have said that." AP-D repeated, "She just kept pushing my buttons." Document review of a policy titled, Vulnerable Adults and Maltreatment -Communication, Prevention, and Reporting, dated April 18, 2018, indicated clients have the right to be free from physical and verbal abuse. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 325		