*Protecting, Maintaining and Improving the Health of All Minnesotans*

# Office of Health Facility Complaints Investigative Public Report

**Maltreatment Report #:** HL29508007M
**Compliance #:** HL29508008C

**Date Concluded:** February 6, 2020

**Name, Address, and County of Licensee Investigated:**
Tealwood Management LLC
1880 Independence Drive
Shakopee, MN 55379
Scott County

**Name, Address, and County of Housing with Services location:**
All Saints Senior Lvg Shakopee
1880 Independence Drive
Shakopee, MN 55379
Scott County

**Facility Type: Home Care Provider**

**Investigator's Name:**
Earl F. Bakke, RN, BSN, MSOL, CEN
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) physically abused the client several times during cares.

**Investigative Findings and Conclusion:**
Abuse was substantiated. The AP#1 was responsible for the maltreatment. AP#1 attempted to force medications into the client's mouth after the client refused. While AP#1's other conduct with the client was concerning, the conduct did not meet the definition of abuse.

AP#2's conduct did not meet the definition of abuse.

The investigation included interviews with the client, family members, and facility staff, including administrative, nursing, and unlicensed personnel. In addition, the investigator contacted law enforcement. The investigator toured the facility, made observations of client and staff interactions and cares, and reviewed video footage of the reported incidents. The facility's policies and internal investigation reports were reviewed.

The client received services from the comprehensive home care provider for assistance with activities of daily living, transfers and escorts, medication management, safety checks, housekeeping, and toileting. The client's medical condition affected his cognitive abilities, and he required the services of a memory care setting. The client's health also limited his ability to walk independently; he required the use of a walker and wheelchair. The client's room had a video camera that was motion activated and recorded in three-minute segments.

Review of facility documentation indicated management was notified that AP#1 was observed on video throwing a pillow on top of the client's face and then quickly pulling the client up in bed. AP#1 was also observed on video pulling the client back down in bed again in a quick manner. Review of the video footage showed that AP#1 assisted the client back to his room. The client was using a walker at the time. The client walked to the front of his recliner and turned around. The video showed AP#1 talking to the client and then walking behind his recliner and talking on a phone. AP#1 finished on the phone. Without any notice to the client, AP#1, with her right hand, grabbed the back of the client's pants and pulled him backward, causing him to fall into the chair. The client's walker tipped to the one side in the process. AP#1 then placed her right hand on the client's right shoulder and appeared to attempt to hold the client in place. In the video, the client appeared visibility surprised by AP #1's actions, and he raised his left arm towards AP#1 and pointed at her.

Later on that same day, the video showed AP#1 walk into the client's room holding a medicine cup in her right hand. AP#1 then held the medicine cup in front of the client while he sat in a recliner. AP#1 leaned closer to the client's mouth. The client reached up and pushed AP#1's hand away. AP#1 returned her hand close to the client's mouth. The client attempted to push her hand again, but the AP #1 came up to a standing position. A nurse was then observed walking into the client's room. AP#1 moved to the client's right side. As the nurse walked towards the client, AP#1 suddenly shoved the medicine cup into the client's mouth/face. The motion caused the client's recliner to move backward. The client immediately reacted by trying to push AP#1 away. AP#1 continued to physically engage the client and, at one point, AP#1 was observed grabbing the client's left arm. The client tried to push AP#1 away and raised his right leg up and out trying to push AP#1 away. The physical exchange between the client and AP #1 lasted 47 seconds. For the first 17 seconds, the nurse can be seen on the video standing still and observing AP #1 and the client's interaction. The nurse then turned and walked away while AP#1 and the client continued in a physical exchange. Nineteen seconds later, the nurse returned, walked over to the client and appeared to try and comfort him. By this time, the client had grabbed ahold of AP#1's arm.

Later that same evening, a video segment showed AP#1 and AP#2 move the client over to his bed with a wheelchair. The client was picked up rather than brought to a standing position. AP#1 and AP#2 moved the client to the bed and put him down in a hasty manner. The client appeared startled by the movements, as noted by him reaching up in a striking manner. Seconds later, AP#2 can be seen grabbing the client's left forearm with both of her hands. Both AP#1 and AP#2

appear to partially lay on top of the client with their bodies and push him farther on to the bed. The client laid in his bed, flat, with no pillow for nearly 4.5 minutes. AP#1 then walked over, picked up a pillow, and tossed it on his face for 3 seconds. AP#1 then removed the pillow, reached underneath the client, and pulled him up into bed in a quick manner. Seconds later, AP#1 moved to the side of the client's bed. AP#1 can be seen pulling the client back down into the bed in the same quick manner.

During an interview, the client's family member said a camera was installed in the client's room after growing concerns with cares not being performed as expected. The family member said the client usually did not have physical outbursts. While he could be resistive to taking his medications, he was easily redirected. The family member had observed the video and said the client appeared to go into a fight or flight reaction due to AP#1 being physical. The family member said the client's movements were consistent with him trying to protect himself. The family member mentioned the client did not normally have the physical strength, but because he was so frightened by AP#1's actions, he felt the need to fight back. The family member said the video footage was downloaded and not manipulated in any fashion.

During an interview, management said the incidents on the video footage were totally inappropriate. Management said staff should never force a client to do anything. If resistive behavior was encountered, staff were supposed to redirect, re-approach, or call for a nurse. Management said AP#1 told them the client was falling, and this was the reason she pulled him into the chair.

During an interview, the nurse observed the video footage and commented that the pulling of the client into the chair was a little fast, but she did not consider it violent. The nurse said she did not see any indications the client was falling or that there was an emergency to justify AP#1 pulling the client backward. The nurse said it was not a proper way to sit a client down in a chair. In regards to the physical engagement with the medicine cup, the nurse said AP#1's behavior was not proper and certainly not the appropriate way to administer medications. The nurse said she had tried to calm the client down. The nurse also said she told AP#1 to stop and leave. The nurse offered no opinion regarding the move to the bed, except to say the movement up and down was a little fast, and the pillow on the face was "no good."

During an interview, AP#1 said she had worked with the client for a long time. On the day in question, AP #1 stated the client was resistive to leaving his room to eat. In the early evening, the client was found on the floor. AP#1 stated she had tried to toilette the client, but he was resistive to that also. AP#1 said if a client became resistive to cares, staff were supposed to call for another staff member or a nurse. AP#1 said the nurse attempted to give the client his medications, not her. AP#1 said she was holding his water. She stated when the client took his medications, he spat one pill out. The client picked up the medicine and put it in his mouth, and AP#1 handed him his water. She stated the client then started fighting. AP#1 said the client grabbed her and was physical first. AP#1 further said she had put the pillow on the client's stomach. AP#1 denied being mad or frustrated with the client. The video of the chair incident

was reviewed with AP#1. AP#1 said the client did not want to sit down. In regards to the video footage of AP#1 holding the medicine cup, AP#1 said she should have tried with another person.

During an interview, AP#2 she had not worked with the client often and did not know his specific medical conditions. She stated a nurse asked AP#2 to come help move the client from his recliner to a wheelchair and then to bed. The client already had on a gait belt. AP#2 said the client was sliding out of the wheelchair and his bed was not working. AP#2 said it was a quick transfer to bed. She stated the client would not stand up. AP#2 said the client suddenly began being resistive so they left him alone. AP#2 said he was kind of stiff. AP#2 said the reason she grabbed the client was to prevent a fall, and the nurse had instructed her to move him. AP#2 said the staff were not supposed to hold down or surprise the clients. Staff were supposed to tell the clients what they were doing and give them time to move because the clients do not do things quickly.

In conclusion, abuse was substantiated against AP#1.

**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;

**Vulnerable Adult interviewed**: Yes.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrators interviewed**: Yes, AP#1 and AP#2.

**Action taken by facility:**
AP#1 and AP#2 were no longer with the facility. Only nurses now administer the client's medications.

**Action taken by the Minnesota Department of Health:**
The MDH found no facility compliance issues at the time of the onsite investigation.

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:
Health Regulation Division – Home Care and Assisted Living Program
The Office of Ombudsman for Long-Term Care
Shakopee Police Department
Scott County Attorney's Office

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H29508 | A. BUILDING: _____ B. WING _____ | C 08/07/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TEALWOOD MANAGEMENT LLC | 1880 INDEPENDENCE DRIVE SHAKOPEE, MN 55379 |

| (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<br><br>******ATTENTION******<br><br>HOME CARE PROVIDER LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>On August 7, 2019, the Minnesota Department of Health initiated an investigation of complaint #HL29508008C/#HL29508007M. At the time of the survey, there were 86 clients receiving services under the comprehensive license.<br><br>The following correction order is issued for #HL29508008C/#HL29508007M, 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.<br><br>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."<br><br>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 | 144A.44, Subd. 1(14) Free From Maltreatment<br><br>Subdivision 1. Statement of rights. A person who receives home care services has these rights: | 0 325 | | |

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| 0 325 | Continued From page 1<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observations, interviews, and document review, one of one client reviewed (C1) was not free from maltreatment. C1 was abused by an individual staff person.<br><br>Findings include:<br><br>On February 6, 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) is required. Refer to the maltreatment public report for details. | |