Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL34669001M
Compliance #: HL34669002C

Date Concluded: December 30, 2019

Name, Address, and County of Licensee Investigated:
Brightstar Care of Scott/Carver
7460 South Park Drive
Savage, MN 55378
Scott County

Facility Type: Home Care Provider

Investigator's Name: Casey DeVries, 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: A client was sexually abused when the alleged perpetrator fondled the client's breast in a manner inconsistent with care needs.

Investigative Findings and Conclusion:
Abuse was substantiated. The alleged perpetrator (AP) was responsible for the maltreatment. There is a preponderance of evidence that the AP engaged in sexual contact with the client; video surveillance footage supported the client's allegation that the AP inappropriately fondled the client's breast.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted law enforcement. The investigation included review of client records, incident reports, personnel records, staffing schedules, policies and procedures, surveillance video, and observation of the client's home and surroundings.

The client's diagnoses included cerebral vascular accident (CVA/Stroke). The client's vulnerabilities included impaired mobility, cognitive impairment and communication difficulty. The client's service plan indicated staff assisted the client with services that included dressing, grooming, toileting, bathing, mobility, transfers, and eating. The client had left-sided paralysis secondary to her stroke and offered little to no participation with cares. The client had a history of agitation, paranoid thinking, and making false accusations. The client was oriented to person, but not always to place or time. The client resided in a private residential home with her spouse. The home care provider typically provided one staff member to the client's home for eight hours daily. During the remaining hours of the day, or if the home care provider did not have staff available, the client's spouse or another provider cared for the client.

During an interview, the client's spouse stated on the morning the incident occurred, the alleged perpetrator (AP) arrived to the home for a scheduled eight-hour shift, at which time, the spouse left for approximately two and a half hours. The spouse stated upon return to the home, the client appeared frightened, indicated to him that she had been sexually molested using sexually explicit terms, and begged him not to leave her. The spouse stated that due to the client's history of making false accusations, initially he did not take the client seriously. The spouse stated later that day, during one of the client's episodes of agitation, he was in the garage next to a baby monitor, which transmitted audio from the client's bedside monitor. The spouse stated he heard the client accuse the AP of trying to steal her husband and that the AP's response was that she would not steal anybody's husband because she liked "girls." The spouse stated that comment, coupled with what the client had said to him earlier, raised his suspicion. The spouse then reviewed surveillance footage from while he was away and discovered during the client's morning cares, the AP had fondled the client's breast in a sexual manner. The spouse stated he immediately attempted to reach the owner of the home care provider, but had to leave a message, so he texted another staff member/unlicensed personnel (ULP) from the home care provider, who had been the client's primary caregiver, to ask how to handle the situation. The spouse stated that the ULP instructed him to ask the AP to go home early and said that she was on her way to the client's home to assist with addressing the matter.

During an interview, the ULP stated the client's spouse showed her the surveillance video when she arrived to the client's home. The ULP stated the video looked to her like a sexual assault, and that the AP's actions were highly inappropriate. The ULP stated she stayed at the client's home to care for the client while the client's spouse called the police. The ULP stated during that time, while caring for the client, the client told the ULP that she had been raped.

During an interview, the home care provider's director of nursing (DON) stated she viewed the surveillance video the day after the incident. The DON stated that a breast massage should never happen and the actions of the AP were inappropriate.

During an interview, the alleged perpetrator (AP) denied that she fondled the client. The AP stated that she was assisting the client to dress after a bed bath when the client began to complain of pain by saying the word "Ow" and that she could tell by the client's face that she

was in pain. The AP stated she asked the client to tell her where her pain was, at which time the client pulled at her right breast. The AP stated she massaged the breast for "a couple of seconds" and denied that she touched the client's nipple. The AP stated it was her personal belief that breasts are not sexual body parts, and she did not see anything wrong with the action she took to make the client comfortable. The AP stated she did not try any other means to alleviate the client's pain.

During an interview, the responding police officer stated he and his partner had discussed upon review of the surveillance video that the AP's action of grabbing, squeezing and rubbing the client's breast was very odd and did not appear to be in any way to be involved with any medical or clinical care that the client needed.

The state investigator reviewed the surveillance video. The investigator observed that the AP used her right hand to massage the client's exposed right breast using circular and squeezing motions over the entire breast, including the client's nipple, for approximately 42 seconds.

A police report indicated the AP began touching the client's right breast in a massaging motion at 10:48:57 hours, and continued until 10:49:39. The officer documented that the touching of the client's breast was, "not associated whatsoever with any sort of caretaking needs." The police arrested the AP the following day and the county attorney's office later charged the AP with 4th degree criminal sexual contact.

Review of the AP's personnel file indicated the home care provider had trained the AP on understanding abuse and neglect, which included inappropriate sexual contact.

In conclusion, abuse was substantiated. There was a preponderance of evidence, through observation, record review and interviews, the AP did not have a care-related reason to be massaging the client's breast. The client's care plan did not direct staff to massage the client in the event of pain, and the AP did not attempt any other means to alleviate the client's pain. After the incident, the client told two individuals that a negative sexual encounter had 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;

(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.

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

Action taken by facility:
The alleged perpetrator 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
Carver County Attorney
Chaska City Attorney
Chaska Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H34669	A. BUILDING: _____ B. WING _____	C 12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR CARE OF SCOTT/CARVER	7460 SOUTH PARK DRIVE SAVAGE, MN 55378

(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 December 13, 2019, the Minnesota Department of Health initiated an investigation of complaint #HL34669002C/#HL34669001M. At the time of the survey, there were #11 clients receiving services under the comprehensive license. The following correction order is issued. The following correction order is issued for #HL34669002C/#HL34669001M, 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=G	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H34669	A. BUILDING: _____ B. WING _____	C 12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR CARE OF SCOTT/CARVER	7460 SOUTH PARK DRIVE SAVAGE, MN 55378

(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
0 325	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 observation, interview and document review, the licensee failed to ensure the right of one of one client (C1) reviewed to be free from maltreatment when a staff member sexually abused the client. 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 was issued at an isolated scope (when one or a limited number of clients are affected or one or limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1's medical record was reviewed. C1 received comprehensive home care services including dressing, grooming, toileting, bathing, mobility, transfers, and eating assist for diagnoses that included cerebral vascular accident (CVA), according to a service agreement dated September 10, 2019. C1's areas of vulnerability included impaired mobility, musculoskeletal problems, cognitive impairment, use of medications, history of previous falls, recent changes in level of independence, sensory changes, and communication difficulties. A police report dated December 1, 2019 indicated	0 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H34669	A. BUILDING: _____ B. WING _____	C 12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR CARE OF SCOTT/CARVER	7460 SOUTH PARK DRIVE SAVAGE, MN 55378

(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
0 325	Continued From page 2 C1's family member (FM)-A reported that surveillance video had captured the sexual assault of C1 by a personal care attendant. The report indicated while FM-A was away from the home for approximately two and a half-hours in the morning, unlicensed personnel (ULP)-D was left to care for C1. When FM-A returned to the home, C1 grabbed FM-A by the arm and stated she had been sexually assaulted. The report indicated FM-A did not initially take C1's statement seriously due to C1's history of false accusations, however, later that afternoon, FM-A overheard ULP-D tell C1, "I wouldn't sleep with your husband, I like girls." The report indicated FM-A found ULP-D's comment odd, which prompted FM-A to review the morning's surveillance video recording. The report indicated law enforcement officer (LEO)-C viewed the video recording. LEO-C documented that based on the video timestamp; ULP-D began touching C1's right breast in a massaging motion at 10:48:57 hours, and continued until 10:49:39. The report noted that the time stamp of the recordings were off by one hour, so the actual time of the incident was at 9:48 a.m. LEO-C documented, "The touching of [C1's] breast were not associated whatsoever with any sort of caretaking needs." The report indicated upon FM-A's review of the video, FM-A contacted another facility staff (ULP-E) who instructed him to tell ULP-D that her shift was over and to leave. The police later arrested ULP-D and charged her with 4th degree criminal sexual contact. A Facility incident report dated December 1, 2019 at 6:36 p.m., indicated that after being asked to leave C1's home, ULP-D contacted facility owner (O)-G to ask what was going on. The report indicated O-G informed ULP-D that FM-A had accused ULP-D of sexually assaulting C1. ULP-D	0 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H34669	A. BUILDING: _____ B. WING _____	C 12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR CARE OF SCOTT/CARVER	7460 SOUTH PARK DRIVE SAVAGE, MN 55378

(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
0 325	Continued From page 3 documented remotely in the facility's electronic incident reporting system that upon giving C1 a bed bath, while ULP-D was moisturizing C1's skin, C1 complained that her chest hurt and started grabbing at her right side. ULP-D indicated that she massaged the right side of C1's chest for one to two minutes, asked C1 if she felt better, and then dressed C1. ULP-D documented that she did not see anything wrong with the actions she took to ensure C1 was comfortable. During an interview on December 20, 2019 at 9:56 a.m., ULP-E stated that she received a text message from FM-A on December 1, 2019 after FM-A had reviewed home surveillance video. ULP-E stated that FM-A told her the video revealed ULP-D had fondled C1's breast and that ULP-D was still in the home at the time. FM-A texted that he had attempted to reach O-G but was unsuccessful so he did not know what to do. ULP-E stated she told FM-A to stay calm, instruct ULP-D to go home, and that she was on her way. ULP-E stated when she arrived to C1's home, FM-A showed her the surveillance video. ULP-E stated she was shocked to see what she thought looked like a sexual assault, and although she did not know ULP-D's intentions, she stated ULP-D's actions were highly inappropriate. ULP-E stated after she reviewed the video, FM-A called the police. ULP-E stated she cared for C1 while FM-A spoke with the police, and during that time, C1 told her she had been raped. During an interview on December 13, 2019 at 11:15 a.m., director of nursing (DON)-B stated she met with FM-A in C1's home the next day on December 2, 2019 and reviewed the surveillance video. DON-B stated that a breast massage should never happen, and the actions of ULP-D	0 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H34669	A. BUILDING: _____ B. WING _____	C 12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR CARE OF SCOTT/CARVER	7460 SOUTH PARK DRIVE SAVAGE, MN 55378

(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
0 325	Continued From page 4 were inappropriate. During an interview on December 13, 2019 at 3:04 p.m., family member (FM)-A stated the day that the incident occurred was ULP-D's second shift working with C1. FM-A stated he left the home at approximately 9:15 a.m., and returned at approximately 12:45 p.m. FM-A stated upon his return, while ULP-D used the restroom, C1's stated that she had been "sexually molested" and was "tittie fucked." FM-A stated that C1 appeared frightened and begged him not to leave, but initially, he did not believe her due to a history of previous false accusations. FM-A stated later that day, at approximately 3:30 p.m., he was in the garage next to a baby monitor, which transmitted sound from C1's bedside monitor. FM-A stated he heard C1 accuse ULP-D of trying to steal her husband and that ULP-D's response was that she would not steal anybody's husband because she liked girls. FM-A stated ULP-D's comment raised his suspicion after what C1 had stated to him earlier, so he decided to review the home's surveillance video recording from the morning. FM-A stated he believed ULP-D fondled C1's breast in a sexual way. FM-A stated since the incident, on multiple occasions, C1 had been more confused and expressed fear that she had been unfaithful to him. FM-A stated C1 believed she was in trouble and that there was a warrant out for her arrest. Additionally, FM-A stated that C1 could no longer have caregivers of ULP-D's ethnicity, due to her on-going fear associated with the incident. During an interview on December 24, 2019 at 11:40 a.m., ULP-D denied that she touched C1 in an inappropriate manner. ULP-D stated that she was assisting C1 to dress after a bed bath when C1 said the word "Ow" and that she could tell by	0 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H34669	A. BUILDING: _____ B. WING _____	C 12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR CARE OF SCOTT/CARVER	7460 SOUTH PARK DRIVE SAVAGE, MN 55378

(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
0 325	Continued From page 5 C1's face that she was in pain. ULP-D stated she asked C1 to tell her where the pain was, at which time C1 pulled at her right breast. ULP-D stated she massaged the breast for "a couple of seconds" and that she did not touch C1's nipple. ULP-D stated it was her personal spiritual belief that breasts are not sexual body parts, and she did not see anything wrong with the action she took to make C1 comfortable. ULP-D stated she did not try any other means to alleviate C1's pain. During observation on December 13, 2019 at 10:27 a.m., the surveyor viewed FM-A's surveillance video taken via director of nursing (DON)-B's cellular phone. The surveyor observed that ULP-D used her gloved right hand to massage C1's exposed right breast using circular and squeezing motions over the entire breast, including C1's nipple, for approximately 41-42 seconds. There was no audio associated with the video. Review of ULP-D's personnel file indicated that the licensee trained ULP-D on understanding abuse and neglect, which included inappropriate sexual contact on November 16, 2019. Licensee's undated policy titled, "Abuse Prevention Program Policy" indicated clients have the right to be free from abuse, neglect and exploitation. The policy defined sexual abuse at any involuntary or non-consensual sexual conduct that would constitute an offense of indecent exposure or assault offenses, committed by the person's caretaker, family member, or any other individual. TIME PERIOD FOR CORRECTION: Seven (7) days	0 325		