DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Report #: HL21006035

Date Concluded: January 3, 2019
Date of Visit: November 6, 7 ,8, 19, 20, and 21, 2018

Name, Address, and County of Facility Investigated:
Chappy's Golden Shores
540 Park Avenue
Hill City, MN 55748
Aitkin County

Name, Address, and County of Housing with Services Registration:
Chappy's Golden Shores
540 Park Avenue
Hill City, MN 55748
Aitkin County

Facility Type: Home Care Provider

Investigator's Name:
Darin Hatch, Special Investigator Senior
Amy Hyers, RN, Special Investigator

Finding: Substantiated, facility and individual responsibility

Nature of Visit:
An unannounced visit was conducted to investigate 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 client was abused by the alleged perpetrators (APs) when AP1, AP2, and AP3 physically assaulted the client. This resulted in an intracranial hemorrhage, pulmonary embolism, and death.

Investigative Findings and Conclusion:
Abuse was substantiated. The facility and AP1 and AP2 were responsible for the maltreatment. The client was abused when AP1 struck the client in the head and face while AP2 held the client down. AP3 stood by, watched the abuse, and did not report the abuse or intervene to stop it. Despite AP3's failure to report or intervene, AP3 was not found responsible for the maltreatment. Several weeks after the abuse, the client was hospitalized for a brain bleed. He died due to complications seven weeks later.

The investigation included interviews with facility staff, former facility staff, hospital nurses, and physicians. The client's facility records, facility incident reports, facility policies and procedures, and hospital records were reviewed. In addition, law enforcement was contacted and a Minnesota Adult Abuse Reporting Center report was submitted by the Minnesota Department of Health because the allegation came about as the result of interviews conducted as part of other ongoing investigations against the provider. The APs were still employed with the provider at the time of this investigation.

The client received comprehensive home care services for diagnoses that included cerebral palsy and cognitive dysfunction. The client was wheelchair dependent and required assistance with all cares and activities of daily living. The client did have difficult behaviors upon admission to the facility.

During interviews with facility staff, former facility staff, family, and the client's support and care team, those interviewed said they witnessed AP1 and AP2 hold the client down and hit him in the head until he was bleeding from his head and face. They said AP1 got mad at the client, and with the help of AP2 to hold him down, AP1 started punching the client. AP3 stood by and did not intervene. They said the client was "freaking out" and trying to defend himself, but was unable to do so because of his cerebral palsy. Several weeks later, when the client was experiencing a change in condition (high blood pressure and increased weakness), the staff called the nurse. The nurse directed the staff to put the client back to bed. The staff were nervous and instead chose to bring the client to the hospital. One staff member chose to drive the client instead of calling for an ambulance. The client was admitted, then transferred via helicopter to a critical care hospital with a brain bleed.

A family member stated she did not believe the facility was providing the correct medical care the client required. She was not surprised to hear of the allegation of abuse. When she arrived at the hospital just before the client passed away, she stated she observed AP1 lying in the hospital bed with the client showing him pornographic pictures on her cell phone.

When interviewed, one staff member stated AP1 "beat the crap out of him [the client]." She stated she saw the aftermath of the client's beating and that he was bleeding from his face. She said she was terrified and wondered how anyone could treat a helpless client in this manner. She stated others reportedly told the owner, but the owner did nothing.

Another staff member said AP1 jumped on top of the client and was punching him in the face. She said this occurred approximately two weeks after his admission to the facility.

A non-nursing management facility staff member said during an interview that staff attempted to call the nurse, but she was "probably sleeping" so they called another staff member instead. She asked for the symptoms and vital signs and determined (as a non-nurse) the client could be sent by a non-emergency medical transportation company. She was on her way to the facility to arrange this when the staff members chose to drive the client to the hospital.

Those interviewed said facility management prohibited staff members from reporting suspected maltreatment, and staff members were not allowed to accurately document what happened as part of attempts by the provider to cover up the incident. Some of those interviewed said AP1 had previously hit another client as well, but management at the facility covered it up and continued to allow AP1 to work around clients.

During an interview with the nurse, who was also the owner, she said the client was very physical, violent, and hitting when he moved in. She said she was "there that day" and no one hit the client. She was asked what day she was referring to and she answered, "The day in question."

During interview, a hospital physician said the determination of death was deemed natural ~~causes due~~ to a non-traumatic brain bleed. ~~He stated had he known about the prior head~~ trauma from the abuse it would have "definitely affected the finding." He said there was a potential that the trauma was related to the client's death.

The APs were interviewed and denied the allegations. AP2 referenced the "incident" date and said the client was hitting at other people and staff. AP2 stated she and AP1 tried to get the client back to his room and after they did, they stepped back. She said, "He slept and got up better."

In conclusion, abuse was substantiated against the facility and AP1 and AP2.

Abuse: Minnesota Statutes section 626.5572, subdivision 2:
"Abuse" means:
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(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;
(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.

Vulnerable Adult interviewed: No. The client is deceased.
Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Yes

Action taken by facility:
No action was taken by the facility to prevent further occurrences of abuse. In fact, facility leadership promoted a culture that encouraged repeated occurrences of abuse by discouraging staff from reporting suspected maltreatment, falsifying records, and failing to train staff to the needs of the client. The APs are all still employed by the facility.

cc: Health Regulation Division – Home Care and Assisted Living Program
The Office of Ombudsman for Long-Term Care
Aitkin County Sheriff
Hill City Police Department
Aitkin County Attorney
Minnesota Board of Nursing