Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL002332923M
Compliance #: HL002334858C

Date Concluded: August 21, 2023
Revised Date: October 25, 2023
Revised by: Benjamin Hanson, Reconsideration Supervisor

Name, Address, and County of Licensee Investigated:
MN Veterans Home Minneapolis
5101 Minnehaha Avenue S
Minneapolis, MN 55417
Hennepin County

Facility Type: Boarding Care Home

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, facility responsibility

Upon reconsideration, the findings of this report were changed to inconclusive.

Nature of Investigation:
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.

Initial Investigation Allegation(s):
The facility emotionally abused a resident when they retaliated against him and treated the resident in a harassing and humiliating manner.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The facility was not responsible for the maltreatment. The facility treated the resident in a harassing and humiliating manner. The facility implemented measures including chemical dependency counseling sessions, random breathalyzers, and random room searches after the resident refused to consent to a breathalyzer test. Facility documentation indicated the resident displayed no symptoms of intoxication and had a long history of sobriety at the time the resident was asked to complete a breathalyzer test. Due to the resident's refusal, a written violation of conduct and corrective action plan were initiated. Interventions included in the action plan made the resident feel violated, humiliated, and targeted by staff. The facility failed to reassess the resident's need to continue with the imposed disciplinary process after the resident reported he felt humiliated by

the interventions but successfully complied with the interventions. The resident was expected to continue to participate in chemical dependency counseling, random breathalyzers, and random room searches for six months.

The investigator conducted interviews with facility staff members, including current and former administrative staff, nursing staff, and unlicensed staff. The investigation included review of facility records including progress notes and assessments, as well as policies and procedures.

The resident resided in a domiciliary boarding care home. The resident's diagnoses included major depressive disorder, type two diabetes, anxiety, and alcohol dependence in remission. The resident's service plan included assistance with coordination of medical care. The resident's assessment indicated the resident was independent with activities of daily living and administered his own medications. The assessment indicated the resident's alcohol dependency had been in remission since 1997. The assessment indicated the resident had no current or past issues with drinking, no history of relapse, nor any other difficulty with maintaining sobriety.

Progress notes from the night the resident received a Code of Conduct Violation indicated another resident reported to staff that the resident was drunk. A staff member went to the resident's room, knocked on the door, and asked him to come to the nurse's station. The resident declined and replied he was sleeping. A facility registered nurse (RN) documented the resident's face was flushed and his eyes were "bloody shot." The Director of Nursing (DON) was called and directed staff to administer a breathalyzer test to the resident. A different nurse returned to the resident's room with a breathalyzer and the resident refused to be tested. A progress note entry completed by a facility licensed practical nurse (LPN) included "no odor of alcohol noted, no slurred speech, no unsteady gait, and no loud or aggressive behavior noted." The resident told staff "This is ridiculous, I've never had a problem about this, I am going to eat my Chinese food and go to bed. I am fine." The nurse noted, "it is unclear whether the resident was drinking because his behavior was WNL [within normal limits] but resident clearly refused assessment of vs [vital signs] and breathalyzer." A third progress note identified the resident's behavior as "baseline", his eye appearance/movement was not at baseline with blood shot eyes noted, and his speech and gait were normal. No odor of alcohol or chemicals were noted, and the resident declined the breathalyzer. Another progress note entry indicated the "resident was found not to be under the influence." A progress note entered the next day indicated the resident's room was searched "due to refusal of breathalyzer" the day prior. No contraband was found in the resident's room.

One week later, a nurse manager's documentation in the progress notes indicated a Code of Conduct and Level of Care Exception (LOCE) had been initiated. However, no changes to the resident's care plan were made "based on face-to-face assessment and evaluation, low risk of chemical use or relapse, history of long-term sobriety, clinical and professional judgment, discussion with care team and resident, new or additional interventions are not warranted. Plan of care was reviewed, and no changes were made." A progress note entered a few days later included "Veteran reported that he feels humiliated by having breathalyzers since he has not had an alcohol problem in many years but will do what he needs to do to move past this incident."

A few weeks later, a progress note indicated the resident met with a staff member to "share some concerns and updates." The resident "reported he had a breathalyzer done prior to his fishing trip and he felt violated and degraded since he does not condone drinking…" One month after the initial incident occurred, a progress note indicated a facility nurse knocked on the resident's door around 9:00 p.m. The resident "swung open the door and yelled what the hell are you doing at my door this time at night?" The facility nurse informed the resident he needed to take a breathalyzer and he "blew hard into the device and slammed the door." The resident's blood alcohol level was noted to be 0.000. Later that night, the resident came down to the nursing office wanting to know who gave the order to do the breathalyzer and reported to staff "this was harassment."

A Code of Conduct Violation policy was provided; however, it was revised seven months after the incident occurred. The licensee was not able to identify what revisions, if any, were made, and did not have a copy of the policy that was in effect at the time of the incident. The policy indicated corrective action steps "may include treatment and care options but can also include a referral to the Level of Care Exception Committee (LOCE) and/or the Utilization Review Committee (UR). Staff were to complete a Code of Conduct Situation Review form that included a summary of the situation, witness statements, and other pertinent documents or information. The form would be reviewed by the Conduct Review Committee (CRC) and a Code of Conduct Review- Decision Report would be completed including a statement of findings regarding the situation/event and provide additional action items the resident must follow. In developing a statement of findings, the CRC was directed to review all the facts, review the resident's history to establish if any patterns or specific needs exist, be fair and consistent, and make a clear statement of what violated the code of conduct. The policy indicated when creating corrective actions for substantiated code of conduct violations, staff should first look to provide support and resources to the resident.

All documentation related to the resident's Code of Conduct Violation and Level of Care Exception (LOCE) was requested and a Code of Conduct Review Committee Decision Report was provided. The report identified the issue was "not consume. Sell, or distribute alcohol, illegal drugs, or non-prescribed medications (sic)" The statement of findings identified "This incident was reviewed, and decision was made on the evidence." The evidence referenced was not listed. Action to be taken was listed as the following: "1. Care team meeting with veteran to address the refusal of the breathalyzer. 2. Veteran will submit to random breathalyzers and the frequency to be determined. 3. Meet with CD [chemical dependency] counselor [name] in person every other Thursday and a phone meeting 4. Staff will review with veteran about the important (sic) of following with requested interventions such as breathalyzers. (Resident Expectations Form) 5. Veteran will meet with vocational counselor [name] regarding continued work therapy placement within the next week." The section for names of care team members and the date were left blank.

Emails between a community advocate and the former administrator, sent a few days after the resident refused the breathalyzer, indicated the community advocate raised concerns about the interventions implemented in response to the Code of Conduct violation. The community advocate wrote to the former administrator "…I understand your facility and that many of your residents have history of issues with substances. Do you think a more fair policy would be to

individually care plan approaches for residents that have issues in this area? The nursing home and boarding care statutes stress individualizing care for residents, and I feel this and other policies you have are too strict and not individualized." The former facility administrator wrote back, "The MVH-Domiciliary Program in both [city name] and [city name] is a sober environment. That means there can be no chemical use as defined in the Domiciliary – Resident Chemical Use policy. A refusal or positive breathalyzer would be in violation of the policy and would trigger a Code of Conduct Violation…"

All current and former staff members interviewed confirmed the resident's alcohol dependency had been in remission for many years and the resident had no incidents related to a lapse in sobriety, having alcohol in his room, or being intoxicated at the facility.

During interviews with current and former staff members, they reported the resident had been identified as a "problem "and it was clear the resident was targeted by some staff since he would frequently voice concerns or challenge changes to rules or new policies. Several current and former staff members reported the measures taken after the resident refused a breathalyzer were done to intimidate the resident and threaten the safety of his housing since a Code of Conduct violation could lead to discharge. Staff indicated the initial report of the resident being drunk was made by another resident who was noted to dislike the resident. Staff members identified the resident had no history of alcohol related noncompliance at the facility and had maintained his sobriety. The staff indicated the resident was not observed drunk the night he refused the breathalyzer. Staff felt management used the incident to initiate discharge of the resident and used the incident to keep him quiet and comply with what they wanted. Staff interviewed reported they overheard several members of management comment about not liking the resident and thought he was too difficult. Several staff members stated a manager would say "just give me a year and [the resident] won't be here," and commented about the resident being difficult. Some staff interviewed felt the interventions implemented were unnecessary and inconsistent with the policy. Staff indicated they tried to voice their concerns but were fearful of retaliation from various people in management, so they did not push the issue and encouraged the resident to comply with the requirements of breathalyzers and chemical dependency counseling.

During an interview with a community advocate, they stated they were notified by the resident the day after he refused to take a breathalyzer. The resident was nervous he would be kicked out and not have a place to live or be removed from his work therapy program. The community advocate stated he was involved in a meeting with the resident and facility management to discuss the Code of Conduct violation and reviewed the fact that while the resident refused the breathalyzer, he was not intoxicated at the time, had no history of being intoxicated at the facility or having alcohol on the premises, so the proposed action items seemed excessive. After the meeting, the community advocate felt everyone agreed that the violation was "a little much" and was told the situation would be reviewed to determine if a formal Code of Conduct violation was needed. However, the next day, the facility indicated they were moving forward with the proposed plan and the violation. The community advocate felt the actions of the facility were excessive and felt they were used to move towards discharging the resident. The community advocate stated the resident told him he felt humiliated, and staff often tried to breathalyze him in front of other people to humiliate him.

During an interview with the resident, he stated in the nearly 18 years he lived at the facility, he had no alcohol related issues. The resident stated the night he was asked to take a breathalyzer, he had been downtown at a restaurant, was visiting with a friend and offered a sample of beer. The resident didn't want to be rude, so he took a few drinks and "apparently another resident that has an issue with me, saw me and told the staff I was drunk." The resident said he was already in bed when staff knocked on his door wanting to breathalyze him. The resident refused because it felt like an invasion of his privacy and thought staff needed probable cause to test him. The resident met with management the next day and asked how they had probable cause since they didn't see him that evening, and all they told him was he had red eyes and flushed cheeks. The resident pointed out to management that the resident who reported him had a history of making false statements. The resident stated the facility did not have probable cause based off red eyes or flushed cheeks, because his eyes were usually red, he had rosacea, so his cheeks are usually flushed, "plus they basically woke me up, how was I supposed to look?" The resident was given a Code of Conduct violation and was told he had to meet with a drug and alcohol counselor and be subject to random breathalyzers, which didn't make sense. "I thought it was just horrible, why are you punishing me? I have a history of never having any drug or alcohol issues, now you're telling me I have to go into a program because I refused to do a breathalyzer?" The resident stated he had to take a few random breathalyzers after the incident and "felt violated, it's abusive, they were just harassing me because I fight for things and stick up for people and ask questions, like why are you changing this rule, and why are you doing this or that." The resident knew several Code of Conduct violations could lead to him being discharged and he felt management was trying to get him to be quiet, or move out, when they told him he had to complete chemical dependency counseling and random breathalyzers. "They were just doing it retaliatorily, they're trying to get you on anything they can, because if you get enough violations they can discharge you, that's what they were working on; is discharging me." The resident stated he told several staff members he felt "violated, humiliated, it's so humiliating, it makes me upset, and I had a hard time sleeping after this." The resident stated he realized he had no choice but to comply with the Level of Care Exception plan. The resident said he didn't try to appeal it because he wouldn't have a fair chance at arguing anything and was afraid he might be discharged if he continued to question things or caused more trouble at the facility.

<u>In conclusion, the Department determined abuse was inconclusive. Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11. "Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.</u>

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment 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;

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Not applicable
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:
No deficiencies are issued as a result of the 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:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Minneapolis City Attorney
Minneapolis Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00233	A. BUILDING: _____ B. WING _____	C 06/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417

(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
3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: Revised due to Reconsideration Process. On June 20, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL002332923M/ HL002334858C.	3 000	The Minnesota Department of Health documents the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes.	

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3 000	Continued From page 1 The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	3 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN, WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	