Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL357378186M
Compliance #: HL357375354C

Date Concluded: April 9, 2024

Name, Address, and County of Licensee Investigated:

Karen Home
11711 Karen Lane
Minnetonka, MN 55343
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela R.N.
Special Investigator

Finding: 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):
A facility staff member/alleged perpetrator (AP) abused the resident when the AP got into a verbal argument and physical altercation with the resident. The AP also did not inform the resident what morning medications were set up in her medication container.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Due to a lack of information, it could not be determined if abuse occurred, and no specific AP was identified. The resident's medical record and staff interviews indicated the resident was provided a list of medications and instructions with each medication administration.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the resident's case manager. The investigation included review of the resident's record, facility documentation, a law enforcement report, and facility policies and procedures. At the time of

the onsite visit, the investigator toured the facility and observed staff's interactions with residents and medication administration.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes mellitus, below the knee amputation, and depression. The resident's service plan included assistance with safety checks, medication management, and medication administration. The resident's assessment indicated the resident had a history of agitation, anxiety, and verbal aggression due to environmental triggers. The assessment indicated the resident could experience disorientation of time and reality, causing social withdrawal. The resident received assistance with medication administration that included for staff to inform the resident what medications were being administered and offering medication instruction as needed.

The resident's medical records indicated the resident had history of aggressive behavior towards staff. Staff were directed to provide reassurance, support, and medication (as needed) for behaviors.

Facility documentation indicated a female staff member/alleged perpetrator (AP) went into the resident's room while the resident was on the phone. The AP and the resident engaged in a verbal argument which led to a physical altercation. The resident reported they felt mistreated by the AP.

The facility's staffing schedule included an overlap of female facility staff who worked at the time of the alleged incident. No further identifying information was provided about the AP, and an AP could not be identified.

The date of the alleged incident, law enforcement was called by the resident to report concerns with staff. The law enforcement report included no identifying information of the staff reported and the case was closed due to lack of evidence to support abuse or neglect occurred.

When facility administration was informed of the alleged incident, a care conference was scheduled with the resident's care team. The care conference included discussion with the resident and their case manager about concerns with staff being insensitive to the resident's chosen gender, being disrespectful regarding the resident's boundaries, and the resident's needs not being met. Following the care conference, facility administration provided staff with training on de-escalation techniques and gender inclusive care.

During an interview, administrative nursing staff stated they could not identify a specific AP but followed up with the resident's case manager after the incident to address the resident's concerns.

During an interview, the resident recalled the incident and stated that the incident made her feel emotionally abused; however, the resident could not identify a specific AP but indicated it was a female staff member.

In conclusion, the Minnesota Department of Health 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.

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: No. Family declined to be interviewed.
Alleged Perpetrator interviewed: N/A; No AP identified

Action taken by facility:
The facility re-trained staff on behavior de-escalation techniques and gender inclusive care.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35737	A. BUILDING: _____ B. WING _____	C 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAREN HOME	11711 KAREN LANE MINNETONKA, MN 55343

(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****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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: #HL357375354C/#HL357378186M On February 8, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 2 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for#HL357375354C/#HL357378186M , tag identification 0730 and 2350.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the	0 730		

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0 730	Continued From page 1 following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution;	0 730		

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0 730	Continued From page 2 (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records included accurate identifying information including the resident's name, preferred gender, and other health history information for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: R1 admitted to the facility on February 6, 2023. R1's medical record included R1's birthname, gender at birth, and R1's chosen gender identity. However, R1's medical record lacked proper identification concerning the resident's chosen (preferred) name. R1's service plan dated February 6, 2023, included only R1's birthname in the document title and not the preferred name of R1. R1 signed the February 6, 2023, service plan with her chosen name identification, which was not indicated	0 730		

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0 730	Continued From page 3 anywhere on the document. R1's Individual Abuse Prevention Plan (IAPP), dated February 6, 2023, indicated R1's birthname and lacked documentation of R1's preferred name, chosen gender, and/or chosen pronoun. R1's care plan dated August 4, 2023, signed by registered nurse (RN)-B, indicated the resident's chosen gender, chosen pronoun, birthname and chosen name; however, the document did not specify R1's preffered name. The care plan also did not always identify R1 by their preferred gender pronoun. R1's nursing assessment dated August 16, 2023, signed by RN-B, indicated R1's birthname in the document title, R1's chosen name, and chosen pronoun, throught the assessment but did not specify R1's preferred identifiers including, name, gender, and pronoun, anywhere in the document. R1's progress notes dated from September 16, 2023 at 6:27 a.m. and September 17, 2023 at 1:38 p.m., signed by unlicensed personnel, (ULP)-H, referred to R1 by their birthname not preferred name. R1's progress note dated September 21, 2023 at 3:30 pm and signed by RN-B, indicated R1's care conference was held and included interventions discussed such as: behavioral de-escalation techniques and that staff needed to avoid calling R1 "he" and discussed staff training regarding gender consideration. In the progress note, RN-B referred to R1 by her birthname not her chosen name. R1's progress notes dated September 29, 2023 at 8:15 p.m. through October 8, 2023 at 8:03 p.m.	0 730		

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0 730	Continued From page 4 referred to R1 by her birthname, not her chosen name, however, referenced with R1's chosen pronoun. An email provided by SW-F on February 23, 2024 at 7:47 a.m., indicated SW-F had a conversation with the licensed assisted living director (LALD)-A, on August 29, 2023 about the misgendering of R1. The email also included SW-F's preparation notes for R1's pre-termination meeting, dated September 12, 2023, to discuss the "transphobia" as it had hindered R1's care from staff. Due to staff's insensitivity regarding R1's gender, R1's needs were not being met, nor are staff respectful of R1's boundaries with the continuation of the misgendering of her. During an interview dated February 15, 2024 at 3:28 p.m., the licensee's owner/unlicensed personnel, (ULP)-I, who was on the schedule the date of the incident, stated R1 was always referred to by her chosen name. During this same interview, ULP-I, used the pronoun "she" approximately one time, pronoun "her" approximately three times, "he" approximately twice and "him" approximately twice when making reference to R1. The Service Plan Policy, undated, indicated R1 services and frequency of services are based on the resident's most current assessment and preferences. TIME PERIOD TO CORRECT: Twenty-One (21) Days	0 730		
02350 SS=G	144G.91 Subd. 7 Courteous treatment	02350		

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02350	Continued From page 5 Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure one of two residents (R1) were treated with courtesy and respect when R1 was not referred to by preferred name, gender, and pronoun identification. This practice resulted in a level three violation (a violation that harmed a resident'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 residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's resident profile document indicated R1 was admitted on February 6, 2023 and included R1's birthname, gender at birth, and R1's chosen gender identity. However, R1's medical record lacked proper identification concerning the resident's chosen (preferred) name. R1's service plan dated February 6, 2023, indicated only R1 required daily assistance with activities of daily living, medication management, safety checks, and housekeeping. R1's undated, Assisted Living Bill of Rights was signed by R1 using her birthname and preferred name. The Bill of Rights document indicated R1 had the right to:	02350		

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02350	Continued From page 6 (1) Appropriate care and services based on R1's needs and an up-to-date service plan. (4) Courteous treatment: R1 had the right to be treated with courtesy and respect. (10) Personal and Treatment Privacy: R1 had the right to consideration of her individuality,cultural identity as related to her psychological well-being. R1's Individual Abuse Prevention Plan (IAPP), dated February 6, 2023, indicated R1 would feel a sense of belonging at the licensee's setting, R1 would experience comfort, and be free from complications from mental health. The IAPP indicated R1's birthname but lacked documentation of R1's preferred name, chosen gender, and/or chosen pronoun. R1's care plan, dated August 4, 2023, signed by registered nurse (RN)-B, indicated the resident did not have any communication deficits but was at risk to abuse staff and other residents. R1's care plan included R1's chosen gender, chosen pronoun, birthname and chosen name; however, the document did not specify R1's prefered name. The care plan also did not always identify R1 by their preferred gender pronoun R1's nursing assessment dated August 16, 2023 signed by RN-B, indicated R1 had a history of agitation, anxiety, and verbal aggression from environmental triggers. The assessment indicated R1 could experience disassociation from reality and withdraw. The care plan did not specify R1's chosen name, gender identity, or chosen prounoun. R1's nursing assessment included R1's birthname in the document title, R1's chosen name, and chosen pronoun, throught the assessment but did not specify R1's preferred identifiers including, name, gender, and	02350		

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02350	Continued From page 7 pronoun, anywhere in the document. R1's service delivery summary dated August 2023, indicated licensee staff managed R1's mental health needs, safety checks and socialization two times per day. R1's progress notes dated August 25, 2023, at 6:02 p.m., indicated R1 displayed aggressive and threatening behavior toward staff. The progress note indicated staff provided mental health support to R1 until hearing response from R1's case manager/social worker (SW)-F. R1's progress notes dated August 26, 2023 at 6:48 p.m., indicated R1 displayed aggressive and threatening behaviors toward staff and law enforcement was called by another resident. The progress note indicated RN-B would arrange a care conference regarding R1's behaviors. The law enforcement report indicated R1 reported conflicts involving staff. This report indicated no evidence was presented of articulable acts of abuse or neglect and the case was closed. A complaint document dated August 26, 2023 at 6:23 a.m., indicated between August 11, 2023 and August 26, 2023, a licensee's staff member (unknown), did not acknowledge R1's gender identity. The complaint indicated R1 and the licensee's staff member got into a physical altercation when R1 was on the phone when staff told R1 she was a man because she had a penis and told R1 she was wicked and rude. R1's progress note dated September 21, 2023 at 3:30 pm and signed by RN-B, indicated R1's care conference was held and included interventions discussed such as: behavioral de-escalation techniques and that staff needed to avoid calling	02350		

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02350	Continued From page 8 R1 "he" and discussed staff training regarding gender consideration. In the progress note, RN-B referred to R1 by her birthname not her chosen name. On September 21, 2023, the licensee provided training to staff entitled Prevention of Escalated Behaviors and Gender Consideration. R1's progress notes dated September 29, 2023 at 8:15 p.m. through October 8, 2023 at 8:03 p.m. referred to R1 by her birthname, not her chosen name, however, referenced with R1's chosen pronoun. R1's discharge summary dated October 18, 2023, signed by RN-B and R1, indicated R1 wanted to continue her care elsewhere. During an interview on February 13, 2024 at 2:01 p.m., R1's case manager/social worker (SW)-F, stated staff at the facility did not identify R1 by their chosen name or gender identity which caused and increase in R1's behavior. R1 discharged from the facility due to these concerns. An email provided by SW-F on February 23, 2024 at 7:47 a.m., indicated SW-F had a conversation with the licensed assisted living director (LALD)-A, on August 29, 2023 about the misgendering of R1. The email also included SW-F's preparation notes for R1's pre-termination meeting, dated September 12, 2023, to discuss the "transphobia" as it had hindered R1's care from staff. Due to staff's insensitivity regarding R1's gender, R1's needs were not being met, nor are staff respectful of R1's boundaries with the continuation of the misgendering of her.	02350		

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02350	Continued From page 9 During an interview dated February 15, 2024 at 3:28 p.m., the licensee's owner and unlicensed personnel, (ULP)-I, who was on the schedule the date of the incident, stated R1 was always referred to by her chosen name. During this same interview, ULP-I, used the pronoun "she" approximately one time, pronoun "her" approximately three times, "he" approximately twice and "him" approximately twice when making reference to R1. During an interview dated February 15, 2024 at 1:03 p.m., R1 stated she did not know the name of the staff member who told her she was a man because she had a penis, she (R1) was gross, wicked and rude. R1 stated the incident made her feel "crappy" and mentally and emotionally abused. The licensee provided Vulnerable Adult Policy dated August 1, 2021, indicated the licensee to develop a plan to minimize the risk of abuse to residents and all staff are considered mandated reporters according to the policy. (b) Abuse is defined as: (2) any non-therapeutic conduct which produces or could reasonably be expected to produce pain or injury and is not accidental or repeated conduct which produces or reasonably be expected to produce mental or emotional distress. The licensee provided Bill of Rights Policy dated November 8, 2022, (4) courteous treatment. Residents have the right to be treated with courtesy and respect. No further information was provided. Time period for correction: Seven (7) days	02350		

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