Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL357373005M
Compliance #: HL357375013C

Date Concluded: August 10, 2023

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: Kris Detsch, RN
Special Investigator

Finding: Not Substantiated

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 neglected a resident when they failed to order his medications which resulted in the disruption of his medication schedule causing him to have periods of depression and mania (overactivity). Additionally, the facility neglected a resident when they failed to recognize they left a box cutter in his room which resulted in the resident cutting himself.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility implemented a process for ordering medications and their documentation indicated the resident received his medications. Additionally, the facility implemented a behavior management plan and provided supervision to the resident. Although the resident said a staff member left a box cutter in his room, he hid it, and management was not aware of the incident. The resident did not injure himself and returned the box cutter to a staff member. The incident was an isolated incident and the resident remained at his baseline health status.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a case manager. The investigation included review of resident records and employee files. Also, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included depression, post-traumatic stress disorder (PTSD), personality disorder, and attention-deficit hyperactivity disorder (ADHD). The resident's service plan included assistance with behavior and medication management, meals, and housekeeping. The resident's nursing assessment indicated he had suicidal ideation.

The resident's progress notes indicated his physician ordered him to start a new medication, but the pharmacy notified the facility his medical insurance would not cover the cost of the medication, so he agreed to pay for the medication. The electronic medication record (eMAR) indicated the resident received his first dosage of the medication the following day. Also, the resident's progress notes indicated there was a medication the resident received in the morning, and the facility changed it to the evening. The eMAR indicated the resident had not missed any dosages of his medication. At the time of these medication changes, the resident's progress notes indicated staff provided close observation and behavior management to him. The resident's progress notes and eMAR indicated there were no further disruptions to the resident's medication schedule.

During an interview, the resident said there was a hole in his window and bugs were getting in, so staff came to fix it. The resident said they left a box cutter in his room, he took it, hid it, and did not tell anyone. The resident said he was in emotional distress, used the box cutter and attempted to cut his wrists. The resident said he was not trying to commit suicide, but he wanted to cause pain and bleeding. The resident said the box cutter was very dull and he did not bleed. The resident said he gave the box cutter to a staff member but could not remember their name. The resident said he had the box cutter for about three or four days. The resident said the facility had a locked closet that was password protected where they kept the knives and sharp objects.

During an interview, the resident said there were quite a few times staff forgot to give him his medications or reorder his medications. The resident said there was a time when he missed two or three days of his medications which caused him to have an episode of depression and an episode of mania (overactivity).

During an interview, a manager said she was unaware of any incident involving a box cutter. The manager said there was an incident when the staff was having a pizza party and the resident requested to eat in his room. The manager said the resident scratched his arms with the pizza box. The caregiver said she monitored the resident and called a nurse to come assess him for injury and mental health. The manager said the resident received no further medical care for this incident.

During an interview, a manger said they go over the medications every week and the resident did not miss medications.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

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

Action taken by facility:
The facility coordinated the residents care with health providers and case managers.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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 07/20/2023

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 On July 20, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL357375013C/#HL357373005M. No correction orders are issued.	0 000		