Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL357514342M
Compliance #: HL357515202C

Date Concluded: October 22, 2024

Name, Address, and County of Licensee Investigated:
Golden Heart Home
5808 70th Street West
Edina, MN 55439
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Katie Germann, 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 alleged perpetrator (AP) abused a resident when the AP poked the resident in the right breast.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The resident stated the AP poked her in the right breast, however, the resident stated the AP did not intentionally poke her breast. The allegation does not rise to the level of abuse.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigation included review of medical records, staff training, staff schedules, and facility policies and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included bipolar disorder, borderline personality disorder, and cerebral infarction. The resident's service plan

included assistance with medication administration, bathing, meals, dressing, toileting, housekeeping, and laundry. The resident's assessment indicated the resident has a history of verbal aggression and resistance to staff direction.

An outside report indicated the resident went downstairs in the facility to visit another resident. After the resident came back upstairs, the resident asked the AP for her inhaler. When the AP went to bring the resident her inhaler, the resident had left and gone downstairs. The AP found the resident and told her not to go downstairs due to her risk of falling. The AP then handed the resident her inhaler and poked the resident in her right breast using her index and middle finger. The resident went back to her own room and locked the door.

During an interview, the resident stated the AP became angry at her because she went downstairs to visit a lady who lived there. The resident stated the AP was concerned she might scare the other resident. The resident stated she is unsure if the AP meant to touch her, but she was worried she might upset the other resident. The resident stated the AP poked her with her index finger. The resident stated the AP did apologize to her and told her she did not mean to scare her or touch her. The resident stated everything has been fine since the incident and the AP and her realize one another's boundaries.

During an interview, the facility administrator stated the resident has a history of going downstairs into other residents' rooms. The administrator stated the resident has taken things from other residents, so they try to keep an eye on her. The resident has the right to go downstairs, but she requires close monitoring. The administrator stated at the time of the incident the AP was a new employee and the resident had not known her very well yet.

During an interview, the AP stated she was told by management the resident should not be downstairs. On the day of the incident, she was trying to keep the resident from going downstairs and into other resident's rooms. The AP denied touching the resident and feels she and the resident have a good relationship.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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, unable.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
No action taken.

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
	35751	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN HEART HOME	5808 WEST 70TH STREET EDINA, MN 55439

(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 September 24, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL357515202C/#HL357514342M. No correction orders are issued.	0 000		