DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54484542M
Compliance #: H54484521C

Date Concluded: December 13, 2024

Name, Address, and County of Licensee Investigated:
Park River Estates Care Center
9899 Avocet Street NW
Coon Rapids, MN 55433
Anoka County

Facility Type: Nursing Home

Evaluator's Name: Christine Bluhm, RN
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:
The alleged perpetrator (AP) financially exploited the resident when she signed out that she gave the resident the narcotic pain medication, but instead the AP diverted the medications.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation (drug diversion) was inconclusive. While there was concern raised the AP may have been diverting medications, the evidence was insufficient to demonstrate it occurred.

The investigator conducted interviews with facility staff members. The investigator also contacted law enforcement. The investigation included review of the resident record, the facility internal investigation, facility incident reports, facility-provided video footage, personnel files, the law enforcement report, and facility medication administration policies.

The resident resided in a skilled nursing facility (nursing home). The resident's diagnoses included cognitive decline, heart disease, and chronic back pain. The resident was hard of hearing and spoke English as a second language. The resident's service plan included full assistance with medication administration and pain management. The resident's pain assessment indicated the resident complained of lower back and leg pain. The resident had scheduled and PRN (as needed) Dilaudid (narcotic pain medication) pills for pain.

The electronic medication administration record (EMAR) indicated the resident had orders for Dilaudid, one 4 milligram (mg) pill four times a day scheduled. Additionally, the same document indicated the resident had an order for Dilaudid one 4 mg pill PRN every two hours for pain.

The AP was an unlicensed caregiver whose duties included passing medications to residents including controlled substances such as Dilaudid.

A concern arose when the AP had removed Dilaudid from the resident's supply but did not administer it to the resident. The facility contacted local law enforcement and the subsequent police report indicated the facility reviewed the video footage. The facility said the video showed the AP accessing the narcotic drawer of the medication cart [where Dilaudid and other controlled substance were stored], removing pills, and then going out of camera view.

A review of the resident's EMAR indicated the AP documented giving most of the Dilaudid PRN during the last month the AP worked there. However, there were other unlicensed caregiver(s) who also administered the Dilaudid PRN during that time and after the AP no longer worked at the facility. A comparison between the EMAR and the narcotic book (where each resident's inventory of controlled substances is inventoried) indicated the AP's documentation between the two were consistent.

During an interview, a nurse stated the AP broke facility policy when she gave as needed narcotic medication to residents without communicating to a nurse first on multiple occasions.

During an interview, a nurse manager stated there was not a concern the resident experienced untreated pain. The nurse manager also stated the resident would not have been able to verbalize and rate a pain "number" although the AP consistently documented the resident rated his pain at an eight out of ten. The manager stated the AP was interviewed about the situation and the AP stated that if she documented the medication, she gave it.

A review of the video footage provided by the facility did show the AP accessing the narcotic box, however the specific medication she is removing cannot be identified in the video. The video showed the AP stepping out of view of the camera, but the view is too distant to determine if or what medications the AP took with her.

The Minnesota Department of Health determined financial exploitation (drug diversion) 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.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority, a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or

Vulnerable Adult interviewed: No.
Family/Responsible Party interviewed: Attempts to interview the family member were unsuccessful.
Alleged Perpetrator interviewed: Attempts to interview the AP were unsuccessful.

Action taken by facility:
The facility conducted an internal investigation. The AP was no longer employed by the facility.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations. 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.

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

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00010	A. BUILDING: ______ B. WING ______	C **12/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIVER ESTATES CARE CENTER	**9899 AVOCET STREET NORTHWEST** **COON RAPIDS, MN 55433**

(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
2 000	Initial Comments *****ATTENTION****** NH 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: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H54484542M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.	2 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the	

Minnesota Department of Health

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2 000	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. No licensing orders are issued.	2 000	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." 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.	