Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL204135802M
Compliance #: HL204138148C

Date Concluded: February 13, 2025

Name, Address, and County of Licensee Investigated:

Trinity Terrace
3330 213th Street West
Farmington, MN 55024
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Danyell Eccleston, 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(s):
The alleged perpetrator (AP) financially exploited the resident when the AP took the residents-controlled medication for their own personal use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was inconclusive. Facility documentation is unclear regarding the amounts of morphine and lorazepam (controlled substances) that were documented as remaining after the resident died and the amounts that were left to be destroyed. Medications were stored in the office used by the AP; however, the AP was not the only individual that had access to the controlled medications.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of the resident records, death record, facility internal investigation, facility incident reports, personnel files, staff schedules, related

facility policy and procedures. Also, the investigator observed staff members providing care, controlled substance storage, and staff members accessing controlled substances.

The resident resided in an assisted living facility with diagnoses including heart failure. The resident's service plan included assistance with medication management, including controlled medications. The resident's assessment indicated the resident had a history of falls, required directions and reminding from others, and was on hospice.

Medication orders for the resident included 5mg morphine tablets and lorazepam 0.5mg tablets.

The facility's Controlled substances inventory and destruction of controlled substances documentation for the resident's supply of morphine and lorazepam included pages with differing counts, some entries whited out, and out of sequence amounts remaining. The specific amounts of morphine and lorazepam left at the facility after the resident died could not be determined off the documentation.

The facility internal investigation indicated multiple facility keys were made by the AP at a hardware store and unlicensed staff had their own set of keys to the facility, including keys to controlled substance storage. The internal investigation also indicated controlled substances and narcotic log documentation were found unlocked in the AP's desk.

During interview, a registered nurse stated during the time in question, controlled substances were kept in a locked apartment in a locked box that nurses and unlicensed staff had keys to access the apartment and lock box. The registered nurse stated narcotics would also be stored in the nurse office in a locked box. The nurse office was typically unlocked during the day and keys to the lock box were in a desk and staff were aware of where the key was stored. The registered nurse stated she and the AP destroyed the resident's left over supply of morphine and lorazepam and documented the destruction of the controlled substances, however, she and the AP backdated the destruction by two weeks to be within facility procedure of destroying medication within 24 hours of resident death. After the AP was no longer working at the facility, the registered nurse stated she noted the resident's-controlled substance counts of how much was left after the resident's death and how much was destroyed did not match. The registered nurse reported the discrepancy to a leadership member.

During interview, a leadership member stated she assisted with the facility investigation of the incident. In the office used by the AP, the leadership member stated they found medication unlocked and boxes of partial resident medications.

During interview, the AP denied taking controlled substances that belonged to the resident or any resident. The AP stated during the time in question, she had recently returned from months of being on leave and was to only be working on a part-time basis due to medical needs. Due to staffing of nurses, the AP worked extended hours and struggled to complete

work. The AP stated she needed to prioritize resident care over documentation and paperwork. The AP stated she worked at the facility a great number of years and never was accused of taking medication and did not know there was an alleged discrepancy in the resident's-controlled substances count until being contacted by the department of health.

In conclusion, the Minnesota Department of Health determined financial exploitation 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
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: Facility conducted internal review of the incident and implemented new controlled substances practices.

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
	20413	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINTY TERRACE	3330 213TH STREET WEST FARMINGTON, MN 55024

(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 November 20, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL204138148C/#HL204135802M. No correction orders are issued.	0 000		