Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL237885168M
Compliance #: HL237888886C

Date Concluded: December 29, 2023

Name, Address, and County of Licensee Investigated:
Ecumen Hutchinson The Pines
1015 Century Avenue SW
Hutchinson, MN 55350
McLeod County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Brooke Anderson, 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), an unlicensed facility staff member, financially exploited three residents (resident #1, resident #2, and resident #3) when the AP removed narcotic medications from the blister pack cards for their own personal use and replaced them with other non-narcotic medications. As a result, the residents were administered medications which were not prescribed.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was not substantiated. Although narcotic diversion occurred, a specific alleged perpetrator could not be identified, as numerous staff were allowed access to the narcotic medications. When suspicion of narcotic diversion was identified, the facility took immediate action, reported the incident, and began an internal investigation. Although resident #1, resident #2, and resident #3 were administered medication not prescribed to them, no harm occurred as a result of the error.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical record, police report, personnel files, and facility policies and procedures. At the time of the onsite visit, the investigator toured the facility and observed interactions between staff and residents.

Resident #1 resided in an assisted living memory care unit. Resident #1's diagnoses included Alzheimer's disease and anxiety disorder. Resident #1's service plan included assistance with bathing, dressing, grooming, oral care, transfers, and medication management. Resident #1's assessment indicated the resident was orientated to person and place, however, unable to give accurate information consistently. Resident #1 was also enrolled in hospice services.

Resident #2 resided in an assisted living facility. Resident #2's diagnoses included type two diabetes, generalized pain, and heart disease. Resident #2's service plan included assistance with bathing, dressing, and medication management. Resident #2's assessment indicated the resident was cognitively intact with some short-term memory loss.

Resident #3 resided in an assisted living facility. Resident #3's diagnoses included anxiety disorder, paraplegia, and traumatic brain injury. Resident #3's service plan included assistance with bathing, dressing, transfers, and medication management. Resident #3's assessment indicated the resident was cognitively intact but had some short-term memory impairments due to the traumatic brain injury.

During a routine medication pass, a facility staff member identified a different shaped pill on resident #1's methadone (opioid medication is used to treat moderate to severe pain) blister pack medication card. The staff member immediately reported the discrepancy and contacted the on-call nurse.

The following day, facility nursing staff followed up on the reported discrepancy of the pill size and shape from the medication card. Nursing staff contacted the pharmacy to review the medication in the blister pack to question if medication was filled correctly. The pharmacy's review confirmed the medication was filled as prescribed; however, pharmacy staff noticed the methadone medication had been replaced with ondansetron (anti-nausea medication) tablets that were of a similar size and shape to the methadone tablets. Upon learning of this, nursing staff contacted the police, reported the narcotic diversion, and began an internal investigation.

The facility's internal investigation included a full reconciliation of the facility's narcotic medication and assessment of affected residents. The internal investigation identified resident #1, resident #2, and resident #3's narcotic medication cards had tape on the back of the pill packaging and the narcotic medications were replaced with non-narcotic medications of a similar shape and color. It was identified that the narcotic medications from the blister packs were being switched out with other non-narcotic medications that were packaged in bottles. The facility replaced all medications identified through the internal investigation. All staff were

educated on narcotic diversion, how to inspect medication cards to identify potential diversion of medication, and nurse notification. Resident #1, resident #2, and resident #3 were assessed by nursing staff and their physicians were notified of the incident.

Resident #1, resident #2, and resident #3's medical records were reviewed and included no evidence of significant adverse effects due to the medication diversion and administration of the medications which were not prescribed.

The police report indicated "approximately 15 staff members" had access to the narcotics and there wasn't sufficient evidence to warrant criminal charges.

During an interview, an unlicensed staff member stated he did not notice any change in condition of the residents around the time of the incident, but if he had, he would have reported the changes to the nurse.

During an interview, the facility nurse indicated the residents involved in the medication diversion were assessed and their medical providers were updated. The facility nurse stated all staff were retrained after the incident and facility procedures were reviewed.

During an interview, Resident #1's family member stated he was notified of the incident and was very pleased with how the facility responded. Resident #1's family member stated the care at the facility was excellent.

Resident #2 and resident #3 were interviewed and stated they were not aware of the incident.

Resident #2 and Resident #3's family members were also interviewed and stated they were not aware of the incident.

In conclusion, the Minnesota Department of Health determined financial exploitation 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.

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: Resident #1: No, resident was not cognitively intact to interview.
Resident #2: Yes.
Resident #3: Yes, however resident declined recorded interview.

Family/Responsible Party interviewed: Resident #1: Yes.
Resident #2: Yes.
Resident #3: Yes.

Alleged Perpetrator interviewed: No, attempts to contact were unsuccessful.

Action taken by facility:
The facility completed an internal investigation, monitored the residents involved, and completed staff education.

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
	23788	A. BUILDING: _____ B. WING _____	C 11/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN HUTCHINSON THE PINES	1015 CENTURY AVENUE SW HUTCHINSON, MN 55350

(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 13, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL237888886C/#HL237885168M. No correction orders are issued.	0 000	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.	