Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL25729001M
Compliance #: HL25729002C

Date Concluded: August 8, 2022

Name, Address, and County of Licensee Investigated:
Select Senior Living Coon Rapids LLC
11350 Martin Street Northwest
Coon Rapids, MN 55433
Anoka County

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

Evaluator's Name: Willette Shafer, RN, Special Investigator
Kris Detsch, RN, Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:
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 residents when the AP took narcotic medication from the facility that was prescribed to resident #1 and resident #2.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. Video footage showed the AP entered the facility after hours and removed the narcotic boxes. The AP told law enforcement that she took resident #1 and resident #2 narcotic medications.

The investigator conducted an interview with nursing leadership. The investigator reviewed resident records, employee file, internal investigation, and facility policies. The investigator reviewed the police report and watched the video surveillance footage.

Resident #1 diagnoses included rheumatoid arthritis, chronic pain syndrome, and opioid dependency. Resident #1's service plan included meal and laundry service, medication management, shower assist, and evening cares.

Resident #2 diagnoses included chronic pulmonary lung disease, fibromyalgia, and chronic pain. Resident #2's service plan included housekeeping and laundry service, shower assist, escort to meals, and medication management.

During an interview, a management staff member said resident #1 and resident #2's narcotic medication was missing from the narcotic box. The management staff said, they watched the video footage, and the AP was seen entering the nursing office and removing the narcotic boxes and then returning the boxes. The management staff member said, prior to this incident, the AP had abruptly quit her employment. The management staff member said, neither resident missed any doses of medication.

Review of the video footage showed the AP removing the narcotic boxes from their location and taking them to a secondary location. Video footage showed the AP placing the narcotic boxes back to their prior location.

According to the police report, the AP admitted to taking resident #1 and resident #2's narcotic medication.

In conclusion, the Minnesota Department of Health determined financial exploitation was substantiated

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult.

Vulnerable Adult interviewed: No, not applicable.
Family/Responsible Party interviewed: No, not applicable.
Alleged Perpetrator interviewed: No, AP did not respond to phone calls or subpoena.

Action taken by facility:
The facility updated their medication destruction policy and protocol. The facility reported the incident to the police.

Action taken by the Minnesota Department of Health:

The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment. 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 Or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Anoka County Attorney
Coon Rapids City Attorney
Coon Rapids Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25729	A. BUILDING: _____ B. WING _____	C 07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SR LVG COON RAPIDS LLC	11350 MARTIN STREET NW 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
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL25729002C/#HL25729001M On July 19, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 77 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL25729002C/#HL25729001M, tag identification 1310, 2360.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
01310 SS=D	144G.60 Subd. 3 Licensed health professionals and nurses	01310		

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01310	Continued From page 1 (a) Licensed health professionals and nurses providing services as employees of a licensed facility must possess a current Minnesota license or registration to practice. (b) Licensed health professionals and registered nurses must be competent in assessing resident needs, planning appropriate services to meet resident needs, implementing services, and supervising staff if assigned. (c) Nothing in this section limits or expands the rights of nurses or licensed health professionals to provide services within the scope of their licenses or registrations, as provided by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing nursing services had a current Minnesota license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: LPN-B's file included a copy of a nursing license with an expiration date of November 30, 2021. According to the Minnesota Board of Nursing, LPN-B's license expired November 30, 2021. On July 20, 2022, at 12:30 p.m., director of nursing (DON)-A confirmed LPN-B's license was	01310		

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01310	Continued From page 2 expired. DON-A said she was unaware LPN-B's license expired until after LPN-B resigned. DON-A said it was up to the employee to ensure their license is current. The licensee's Employee Records policy dated August 1, 2021, indicated employee records would contain evidence of current professional licensure. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews, and document review, the facility failed to ensure one of 77 residents reviewed (R1) was free from maltreatment. R1 was financial exploited. Findings include: On August 8, 2022, the Minnesota Department of Health (MDH) issued a determination that financial exploitation occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	