Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL259044641M
Compliance #: HL259045980C

Date Concluded: November 14, 2024

Name, Address, and County of Licensee Investigated:
Bridgewell Assisted Living
410 West Main Street
Osakis, MN 56360
Douglas County

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

Evaluator's Name: Barbara Axness, 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), an unlicensed personnel (ULP), financially exploited the resident when she took a narcotic pain medication for her own personal use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was inconclusive. Although the AP was responsible for medication administration and in possession of the keys for the narcotic box at the time the medication discrepancy occurred, there was not a preponderance of evidence to determine if the AP took the medication. A drug test completed after the allegation was reported was negative and the AP denied taking the medication.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement. The investigation included review of the resident record, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, law enforcement

reports, surveillance footage, and related facility policies and procedures. Also, the investigator observed narcotic storage and medication administration at the facility.

The resident resided in an assisted living memory care unit with a diagnosis of Alzheimer's disease. The resident's service plan included assistance with dressing, grooming, toileting, and medication administration. The resident's assessment indicated the resident had chronic pain and relied on staff to administer all medications.

The resident had physician's orders for Norco (a narcotic pain medication) twice daily, at 8:00 a.m. and 8:00 p.m., for chronic pain.

During a routine narcotic count, a discrepancy was noted in the resident's available Norco tablets and the last recorded entry in the narcotic count book. The discrepancy was reported, and facility administration initiated an internal investigation.

Internal investigation documentation indicated the AP was responsible for medication administration and was in possession of the keys for the narcotic box at the time the discrepancy occurred. Surveillance footage showed the AP accessed the narcotic box and popping of a pill package was heard and fumbling with packaging was observed. The AP appeared to have a white pill in her left hand that she continued to hold until her coworker came into the office. It appeared that the AP then placed the pill in her left pocket. The AP was provided the opportunity to watch the video and could not explain what she was doing with the pill container in the video or where the medication went. The AP was suspended pending the results of the investigation and a urine drug test. The drug test indicated the missing narcotic was not present in the AP's system.

During an interview, a facility nurse stated they were suspicious of the amount of time the AP spent at the medication cart and that the AP did not follow facility protocol for medications that were found on the floor. The nurse stated it would not have been the employee's responsibility to identify the medication they found; they were to place it in an envelope, lock it in the narcotic box, and notify the nurse. The nurse stated they had prior concerns about drug diversion related to the AP and based on her behavior at the medication cart and the unaccounted narcotic, the decision was made to terminate her employment.

During an interview, the AP denied taking any narcotic medications or writing over the count in the narcotic logbook. The AP stated she was trying to match up the pill she found on the floor and was comparing it to other medications, including narcotics, to see if it was an essential medication that wasn't given. The AP stated it was not in the facility policy to match the medication, but she had worked in healthcare for a while and that was just the way she did it. The AP stated she watched the surveillance footage and did not hear the popping of the pill package. The AP stated it was common practice for staff at the facility to write over a narcotic count if it was off, so it could have been anyone who wrote over the count. The AP stated she

cooperated with the facility’s investigation and agreed to take the drug test, which came back negative, because she did not have anything to hide and did not take any narcotics.

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, due to cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility immediately investigated the discrepancy in narcotics and contacted law enforcement.

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
	25904	A. BUILDING: _____ B. WING _____	C 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWELL ASSISTED LIVING	410 WEST MAIN STREET OSAKIS, MN 56360

(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 20, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL259044641M/#HL259045980C. No correction orders are issued.	0 000		