Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL293626022M
Compliance #: HL293628701C

Date Concluded: January 15, 2025

Name, Address, and County of Licensee Investigated:
Arbors at Ridges of Burnsville
13897 Community Drive
Burnsville, MN 55337
Dakota County

Facility Type: Assisted Living Facility (ALF)

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 the AP signed out that she gave the medication but instead diverted the medication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was inconclusive. The investigation found a possible concern for drug diversion, however there was not enough evidence to determine if drug diversion truly occurred.

The investigator conducted interviews with facility staff members. The investigation included review of the resident record, pharmacy and facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. A police report was also reviewed.

The resident resided in an assisted living facility. The resident's diagnoses included stroke with left-sided weakness. The resident's service plan included assistance with all activities of daily living and medication administration. The resident's assessment indicated she had lower back pain for which she took pain medication, morphine dissolvable tablets administered by unlicensed caregivers. The resident had vision impairment related to the stroke.

A pharmacy investigation summary indicated one day the AP was at the med cart and reached into her pocket to retrieve facility keys and a pill in an orange plastic bubble pack fell out. A witness stated the pill in an orange-colored bubble package similar to narcotic medication prescribed by hospice for residents at the facility. There were two residents on that floor with this prescribed medication at that time. Later, when management asked the AP about the medication, the AP stated it was her personal medication. The facility asked the AP to show a sample of the medication she was referring to she was unable to do so initially.

The resident's EMAR indicated the AP passed medications on the day of the described incident. The AP signed out she gave the morphine medication, one tab in the morning and one tab in the afternoon to the resident. The MAR indicated the AP signed out she administered the morphine to the resident three days that month and three days the month prior.

During the onsite visit to the facility, the resident's morphine medication was observed in single dose orange-colored bubble packaging.

During interview, an unlicensed caregiver stated she witnessed a tablet in orange-colored bubble packaging fall out of the AP's pocket when the AP reached in her pocket for the facility keys. The caregiver stated she had no doubt it was resident's morphine even though the AP stated it was her personal medication.

During an interview, a nurse stated the resident's morphine tablets are distinctly packaged for hospice residents. The nurse stated she asked the AP multiple times to provide in person or a photo of the medication that she claimed she took and dropped from her pocket that day. The nurse stated the AP had shown photos and those pills did not look like the orange pill in question.

During an interview, the AP stated she did not have a pill from her personal supply as she had run out to show the facility. The AP stated it was not the resident's medication. When asked what medication she was taking at the time she identified a medication that was not morphine and that this was the medication that fell out of her pocket that day.

The investigation identified no other persons aside from the unlicensed caregiver and the AP saw the medication in question.

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: Yes, with her spouse present.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility and pharmacy investigated the incident. The AP no longer works at the facility.

Action taken by the Minnesota Department of Health:
No further action 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
	29362	A. BUILDING: _____ B. WING _____	C 12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS AT RIDGES ASSISTED LIVING	13897 COMMUNITY DRIVE BURNSVILLE, MN 55337

(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 December 23, 2024, the Minnesota Department of Health initiated an investigation of complaint HL293628701C /HL293626022M. 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.	