Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304065801M
Compliance #: HL304068143C

Date Concluded: November 5, 2024

Name, Address, and County of Licensee Investigated:
Sunrise Village of Milaca
115 9th Street NW
Milaca, MN 56353
Mille Lacs County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Katherine Barnhardt, 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), facility staff, financially exploited the resident when the AP took the resident's narcotics for personal use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was not substantiated. The AP ended employment two days before the narcotic medication card containing Oxycodone (opioid) 10 pills, was reported missing. Multiple unlicensed staff signed off the narcotic count was accurate for two days following the last shift worked by the AP.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff. The investigator contacted law enforcement and the alleged perpetrator. The investigation included review of the resident record, hospital records, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes and degenerative disc disease (worn out vertebral discs). The resident's service plan included assistance with medication administration and activities of daily living. The resident's assessment indicated the resident utilized a manual wheelchair for mobility, was alert and oriented, experienced pain daily and had a provider order for Oxycodone 5 milligrams every six hours as needed for pain.

The middle of one month, a medication card for the resident was delivered to the facility and contained Oxycodone 15 pills and entered into the resident's electronic medication record. The resident's record indicated the resident was administered the narcotic five times over a three-day period. Three days after the narcotic was delivered to the facility the resident transferred to another facility and the resident's narcotic medication was not transferred with the resident. Ten days after the resident transferred out of the facility, unlicensed staff reported the medication card containing the Oxycodone with 10 pills remaining, was missing.

The facility's internal investigation indicated the AP sent a message to management ending employment effective upon completing of a last shift on a Friday and the AP was moving out of state. The internal investigation indicated narcotics were reported missing for the resident the following Monday. The internal investigation determined the narcotic count was completed five times by two staff at each shift change after the AP's last shift. Unlicensed staff signed off after each of those shifts the narcotic count was accurate. On the fifth count unlicensed staff discovered the entire medication card containing the resident's Oxycodone 10 pills was missing and reported the missing medication to licensed staff.

During interviews, multiple unlicensed staff stated the AP's last shift was on a Friday night. Multiple unlicensed staff stated narcotics were counted each shift change throughout the weekend following the AP's last shift and the narcotic count was correct. On the fifth shift change during the narcotic count Monday morning, unlicensed staff alerted licensed staff of a discrepancy in the narcotic count and that a medication card containing the resident's Oxycodone 10 pills was missing.

During an interview, licensed staff stated an internal investigation was conducted Monday morning when unlicensed staff reported a medication card containing the resident's Oxycodone 10 pills was missing. The licensed staff stated unlicensed staff signed off every shift from Friday night and throughout the weekend that the narcotic count was accurate. Licensed staff stated unlicensed staff assumed licensed staff removed the resident's Oxycodone medication card from the locked medication cart after the resident was discharged. Licensed staff stated it was possible unlicensed staff working the weekend shifts would not have been aware an entire medication card with the resident's Oxycodone pills was missing until an unlicensed staff who knew the medication card should be there, returned to work on Monday morning. Licensed staff stated attempts were made to reach the AP and the AP had not responded to any calls. Licensed staff stated local law enforcement had not been notified of the missing narcotics.

During an interview, the alleged perpetrator denied taking the resident's narcotics and stated she was already out of state when the narcotics were reported missing. The AP denied licensed staff had attempted to contact her.

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: No.
Family/Responsible Party interviewed: Attempted.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation.

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
	30406	A. BUILDING: _____ B. WING _____	C 10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE VILLAGE OF MILACA	115 9TH STREET NW #120 MILACA, MN 56353

(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 October 21, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL304065801M/#HL304068143C. No correction orders are issued.	0 000	Assisted Living Provider 144G. 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.	