Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304155423M
Compliance #: HL304159224C

Date Concluded: May 9, 2023

Name, Address, and County of Licensee Investigated:

New Perspective Waconia
500 S. Cherry Street
Waconia, MN 55387
Carver County

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

Evaluator's Name:
Jana Wegener, 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), facility staff, neglected resident #1 and resident #2 when he administered his own personal controlled drug oxycodone (pain medication), and Tylenol to resident #1, and gave resident #2 a Delta 9 tetrahydrocannabinol (THC) edible gummy. Resident #2 was harmed when she had a change in level of consciousness and was transferred to the emergency department.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP admitted giving resident #1 Tylenol from his personal medications and gave resident #2 Delta 9 THC gummies on two separate occasions. Resident #2's emergency department (ED) toxicology report identified THC and methamphetamine in the resident's system after consuming the Delta 9 THC gummy provided by the AP.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, the resident's family member, and power of attorney. The investigation included review of facility investigation documents, resident facility and hospital medical records, AP personnel files, and facility policy and procedures.

Resident #1 resided in an assisted living facility with diagnoses including Type II Diabetes, congestive heart failure, atrial fibrillation, seizure disorder, hypertension, coronary artery disease, and chronic kidney disease.

Resident #1's assessment indicated the resident did not have the ability to manage her own medications and received insulin, steroids, and anticoagulant medications. The resident's service plan indicated the resident received medication management services and administration from the facility.

The facility investigation indicated one day Resident #1 reported to facility staff she told the AP she had a backache, and the AP offered her Tylenol and Oxycodone. When interviewed by the facility the resident stated the AP indicated he "had something good for her" and the AP went to his vehicle and returned with two kinds of pills which were inside a Tylenol bottle. The facility investigation indicated one of the pills was oblong shaped and looked like Tylenol, and the other was a small round pill which the resident recognized as oxycodone. The resident stated the AP told her she could take one of each pill. The resident indicated she took the Tylenol provided by the AP but refused the small round pill, which was believed to have been oxycodone.

Resident #1's medication administration record (MAR) indicated the resident had multiple drug allergies and was prescribed acetaminophen Tylenol 325 milligrams (mg) with instructions to take two tablets every six hours as needed (PRN) for pain, and every night at bedtime. However, the record lacked documentation of the Tylenol administered by the AP and had no orders for oxycodone at the time of the incident.

When interviewed the staff member assigned to pass medications the day of the incident stated the AP never reported resident #1 was having pain and needed, or received Tylenol from the AP.

When interviewed the resident's family member indicated resident #1 used to work in a pharmacy and was very familiar with what oxycodone looked like, and indicated the resident reported the AP had offered it to her but she declined.

Resident #2 resided in an assisted living facility with diagnoses including Type II Diabetes, Hemiparesis following stroke, myocardial infarction, heart failure, atrial fibrillation, and hypertension.

Resident #2's assessment indicated the resident did not have the ability to manage her own medications and received insulin, multiple anticoagulants, heart, and blood pressure medications. The resident's service plan indicated the resident received medication management services and administration from the facility.

Resident #2's MAR lacked orders for medical cannabis.

The facility investigation indicated one day staff responded to resident #2's call light and the resident had a hard time sitting up, had slurred speech, vomiting, and elevated blood pressure. The resident reported to staff she was "high" and had taken an edible gummy. The investigation indicated a provider onsite at the time recommended transfer to the emergency department (ED) for evaluation. The facility investigation indicated when interviewed the AP admitted providing the resident with a Delta 9, THC 5 mg gummy, on two separate occasions.

Resident #2's ED after visit summary and toxicology report indicated the resident tested positive for THC and methamphetamine after taking the Delta 9 THC gummy provided by the AP.

When interviewed, resident #2 indicated the first THC gummy provided by the AP did not "do anything", so the AP brought another THC gummy a couple days later. Resident #2 stated the AP indicated the second gummy was "stronger". The resident stated after she took the gummy, she felt high, and did not remember anything else. The resident stated she trusted the AP and was unaware the THC gummy provided by the AP had methamphetamine in it.

A review of the AP's personnel files indicated although he had received training to pass medications, a disciplinary action form indicated his ability to administer medications to residents was revoked two weeks prior to the incident, due to multiple medication errors.

When interviewed facility staff stated resident #2 had slurred speech, could not sit up and was unable to stand, was vomiting, and reported she had taken an edible gummy provided by the AP and was "very high".

When interviewed, the AP stated resident #1 had pain and he could not find the staff assigned to pass medications, so he gave her Tylenol from his backpack. The AP indicated he told the resident he could get her oxycodone but was joking. The AP stated he never communicated to the staff passing medications that resident #1 had pain or received Tylenol. The AP indicated he didn't like to see a resident in pain and did not want resident #1 to have to wait for the staff to administer Tylenol. The AP stated resident #2 asked him to bring the THC gummies on two separate occasions, and he was not aware the THC gummy contained methamphetamine.

In conclusion, neglect 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: Yes - resident #1, resident #2 unable
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility transferred resident #2 to the ED, suspended the AP, reported the incidents to the Minnesota Adult Abuse Reporting Center (MAARC), investigated the allegations, and provided education to staff. The AP is no longer employed by the facility.

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
Carver County Attorney
Waconia City Attorney
Waconia Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30415	A. BUILDING: _____ B. WING _____	C 04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - WACONIA	500 CHERRY STREET WACONIA, MN 55387

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, 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: On April 26, 2023, the Minnesota Department of Health conducted a complaint investigation for HL33524001M, and HL33524002C, at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 98 residents receiving services under the provider's Assisted Living Dementia Care license. The following correction orders was issued for HL304155423M/HL304159224C, tag identification 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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 1 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure two of two residents reviewed, (R1, and R2) were free from maltreatment. R1, and R2 were neglected. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	