Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306365426M
Compliance #: HL306367544C

Date Concluded: November 8, 2024

Name, Address, and County of Licensee Investigated:
Deer Crest Senior Living
470 Hewitt Blvd
Red Wing, MN 55066
Goodhue County

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

Evaluator's Name: Deb Schillinger RN BSN
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, an unlicensed caregiver, financially exploited the resident when opioid medications were missing from the resident's supply.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was inconclusive. The investigation indicated tape was present on the narcotic medication card and a different medication was taped in spaces on the narcotic card, however, it was inconclusive that the alleged perpetrator was the specific person who diverted the narcotic medication. The length of time the tape was reportedly on the back of the narcotic card increased the number of individuals who may have switched out the narcotics.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record(s), facility internal investigation, facility

incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed staff to resident interactions and narcotic count in facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease and a fractured left radius (bone in wrist area). The resident's assessment indicated the resident had both short- and long-term memory impairment and required the assistance of one unlicensed caregiver for transfers from bed to wheelchair. The resident's service plan included assistance with transfers, assistance with placing to a brace and sling to her left arm, and medication administration. The resident was experiencing pain in her left arm after a fall with fracture; the pain was managed with narcotic medications administered by unlicensed caregivers.

The facility internal investigation indicated a concern was reported to facility nurse #1 regarding tape which was found on the back of the resident's narcotic medication card. Nurse #1 later discovered the medications taped in the narcotic card spaces were not the prescribed narcotic medication but had been switched out for a different medication raising the concern someone had taken the resident's narcotics.

Upon reviewing the security video, the managers found that the alleged perpetrator had suspicious behavior viewed on the video. However, the only video footage was dated on the day the staff member(s) reported the tape on the narcotic card to the facility nurses. The internal investigation included notes from interviews. Those interview notes indicated staff members accounts said the tape had been present for up to 4 days on the narcotic medication card before it was brought to the attention of managers and nursing staff.

During investigative interviews, multiple unlicensed caregivers reported they noticed tape on the narcotic medication card several days before it was reported to the nursing staff but did not report the incident because the narcotic count was correct.

During an interview, the alleged perpetrator stated she reported the tape on the narcotic medication card to a nurse [a nurse other than nurse #1] who verified the narcotic count was correct. The alleged perpetrator stated she did view the security video footage dated the same day the incident was reported to the facility nurses. She stated she did place tape on the medication card to reinforce the tape that was already present. She also stated she did not take the narcotic medication.

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
(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:
(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or
(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.
(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, cognitively impaired
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: The facility completed an internal investigation and alleged perpetrator is no longer employed at facility. The facility reviewed its procedure for medication storage and provided education for unlicensed caregivers to report irregularities such as this right away.

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
	30636	A. BUILDING: _____ B. WING _____	C 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER CREST SENIOR LIVING	470 HEWITT BOULEVARD RED WING, MN 55066

(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 15, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL306367544C/#HL306365426M. No correction orders are issued.	0 000		