Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL30638001M
Compliance #: HL30638002C

Date Concluded: March 18, 2022

Name, Address, and County of Licensee Investigated:
Ecumen North Branch
5379 383rd Street
North Branch, MN 55056
Chisago County

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

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Substantiated, facility 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.

Allegation(s):
It is alleged: Multiple residents, (R1, R2, and R3), were financially exploited by narcotic diversion when a total of 43 Oxycodone tablets went missing from the facility.

Investigative Findings and Conclusion:
Financial exploitation was substantiated. The facility was responsible for the maltreatment. R1 was missing 20 Oxycodone, R2 was missing 9 Oxycodone, and R3 was missing 14 Oxycodone. The facility failed to ensure they had a processes of tracking resident narcotics to identify and prevent drug diversion.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator reviewed the residents medical record, employee records, and facility policy and procedures. Observations of current narcotic medication practices including logging, counting, and monitoring to prevent narcotic diversion were completed. In addition, the investigator contacted law enforcement.

The residents (R1, R2, and R3) were admitted to the facility and had orders for Oxycodone 5mg as needed (PRN) and received medication management services from the facility. R1 and R2 never used the Oxycodone medication prescribed, and R3 was only administered one tablet and was not actively utilizing the medication at the time of the incident.

During a routine weekly narcotic audit completed by two nursing staff, it was noted R1's medication card containing 20 tablets of 5 mg Oxycodone narcotic medication was missing.

The facility investigation of R1's missing Oxycodone indicated when staff were interviewed, they had not completed a shift-to-shift narcotic count using the narcotic index. As a result, staff were only counting the number of pills for each resident's medication cards in the cart and did not notice R1's Oxycodone was missing.

A review of the facility weekly nursing narcotic audits indicated no audit [count] was completed the week prior to identifying R1's missing oxycodone medication. The audit completion dates indicated it had been 14 days since the last narcotic audit was completed.

One week later during a routine weekly narcotic audit completed by two nursing staff it was noted R2 was missing nine Oxycodone tablets.

Facility nursing staff completed an in-depth facility wide audit reviewing all the resident's narcotic index, administration records, and individual narcotic logs and identified R3 was missing 14 Oxycodone tablets.

The facility investigation of R2 and R3's missing narcotic medication indicated the narcotic index had been highlighted with a yellow marker and a false discontinuation destruction date entered. The investigation identified when facility staff used the index to lead the narcotic medication count, they did not notice the medication was missing because the index was yellowed out and the medications appeared to be discontinued. As a result, staff had not noticed R2 and R3's Oxycodone medication cards were missing.

When interviewed facility staff stated they were not able to identify how or when R1, R2, and R3's oxycodone went missing due to the inconsistent narcotic tracking.

In conclusion, financial exploitation 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.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:

(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
F**amily/Responsible Party interviewed**: No
Alleged Perpetrator interviewed: N/A – No AP able to be identified.

Action taken by facility:
The facility provided education to staff on proper medication tracking and counting practices to prevent diversion. A new process was implemented to include counting the number of narcotics cards to be tracked. Nursing narcotic audits were completed daily to ensure competency and accuracy of tracking the narcotics in the facility, no additional concerns were identified. The facility reviewed all unused PRN narcotics in the building and determined if able to discontinue to reduce the risk for potential diversion with unused narcotic medications. Medications are routinely reviewed and discontinued as appropriate if not in use.

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
Chisago County Attorney
North Branch City Attorney
North Branch Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30638	A. BUILDING: _____ B. WING _____	C 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN NORTH BRANCH	5379 383RD STREET NORTH BRANCH, MN 55056

(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 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 January 27, 2022, the Minnesota Department of Health conducted a complaint investigation for HL30638001M/ HL30638002C at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 74 residents receiving services under the provider's Assisted Living license. The following correction orders was issued for HL30638001M/HL30638002C, 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,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the licensee failed to ensure three of thre residents (R1, R2, and R3) reviewed were free from maltreatment. R1, R2, and R3 were financially exploited. Findings include: On January 27, 2022, the Minnesota Department of Health (MDH) issued a determination that financial exploitation occurred for R1, R2, and R3 (HL30638001M), the facility was responcible for the maltreatment in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	