

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307386201M
Compliance #: HL307389162C

Date Concluded: January 30, 2025

Name, Address, and County of Licensee

Investigated:

Edgewood Virginia I Senior Living LLC
605 17th Street North
Virginia, MN 55792
St. Louis County

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

Evaluator's Name: Barbara Axness, 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(s):

The alleged perpetrator (AP), a licensed practical nurse (LPN) at the facility, financially exploited resident #1 and resident #2 when she took the residents' narcotic pain medication for her own use.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined financial exploitation was inconclusive. While both resident #1 and resident #2 had discrepancies in their narcotic medication counts, it was unable to be determined what happened to the medications and there was not a preponderance of evidence that the AP/LPN took the medications.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident records, facility internal investigation

documentation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed narcotic storage in the facility.

Resident #1 resided in an assisted living facility. The resident's diagnoses included heart failure. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident was on hospice and utilized morphine (narcotic pain medication) for comfort.

Resident #2 resided in an assisted living facility. The resident's diagnoses included neurocognitive disorder and vascular dementia. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident was on hospice.

Resident #1

The facility's internal investigation indicated they attempted to talk to the AP/LPN about a medication error but did not disclose who the resident was or what medication was identified as part of the error. The AP/LPN reported to facility management that she is "allergic to morphine" and denied taking the resident's morphine medication.

The facility investigation included a report showing log in attempts to the facility's electronic medical record (EMR). Attempts to log into the clinical nurse supervisor and another facility nurse's profile were made from an IP address the facility attributed to the AP/LPN.

In reviewing the resident's medication administration record (MAR), it was identified the order for resident #1's 15 milligram (mg) Morphine was deleted and then re-added, which allowed the narcotic count to be reset, so a discrepancy in the pill count would not be flagged. The AP/LPN was the user who deleted and modified the order. The count was initially 24 pills, then 23 after the AP/LPN gave one at 9:58 p.m. When counting that evening around 10 p.m., the count was 19 pills. However, the computer did not flag that four pills were missing because the count had reset after the order was deleted and re-added. The facility was unable to reconcile where the four missing pills went.

Resident #2

The facility's internal investigation indicated the AP/LPN administered three extra doses of Hydrocodone/APAP 5/325 milligrams (mg) to resident #2. The AP/LPN did not document administering the three extra medications or ensure the medication was counted in the narcotic log. Medication error reports indicated the AP/LPN administered an extra dose of Hydrocodone/APAP 5/325 mg around 2:00 p.m. but "did not check the MAR to see if it was already administered, nor did she record in the MAR that she administered it. The medication was correctly documented by another medication passer as being given at 1:28 p.m." A second medication error report indicated the AP/LPN gave two doses of Hydrocodone/APAP 5/325 mg around 4:30 p.m., [AP/LPN] thought it was 9 pm. She did not sign it out of the MAR. She also did not sign it on the card itself with her initials and date."

A photocopy of the narcotic card showed all but three narcotics were signed out with the date and staff initials written next to the bubble where the medication was.

In reviewing resident #2's MAR, it was identified the order for Hydrocodone/APAP 5/325 mg was deleted and then re-added, which allowed the narcotic count to be reset so a discrepancy in the pill count would not be flagged. The user who deleted the order was another facility nurse who denied deleting the order. The other user logged into the EMR under an IP address affiliated with the AP/LPN.

The internal investigation included a text message conversation with the AP/LPN. The AP/LPN wrote that she had made a medication error due to have a migraine and could not recall why she gave extra doses and failed to sign them out. Facility management later spoke with the AP/LPN over the phone, and she denied taking the resident's medications and again attributed the errors to having a migraine.

During an interview, facility management stated they were notified of the medication error, so the clinical nurse supervisor came in to assess the resident and make sure she was ok and she seemed fine and they did not suspect she had received three additional doses of her narcotic pain medication over a five hour span. Facility management stated they started an investigation to figure out how the error happened and subsequently identified some other concerns related to the AP/LPN's nursing practices and narcotic medications, which led to her termination.

The AP/LPN provided a text message statement to the investigator but declined to be interviewed. The AP/LPN denied taking medications from residents at the facility and that the allegations were false.

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

"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: Resident #1 and resident #2 unable to be interviewed due to cognitive impairment.

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Yes

Action taken by facility:

The facility suspended the AP/LPN and investigated the incident. The facility contacted law enforcement and made a MAARC report. Upon completion of the investigation, the AP was terminated. All employees were retrained on medication administration practices.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/04/2024
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NAME OF PROVIDER OR SUPPLIER EDGEWOOD VIRGINIA I SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 705 17TH STREET NORTH VIRGINIA, MN 55792
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(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	<p>Initial Comments</p> <p>On December 4, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL307386201M/#HL307389162C. No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____