DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL30786001M
**Compliance #:** HL30786002C

**Date Concluded:** April 15, 2022

**Name, Address, and County of Licensee Investigated:**
Faribault Senior Living
843 Faribault Road
Faribault, MN 55021
Rice County

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

**Evaluator's Name:** Christine Bluhm, 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.

**Allegation:** It is alleged that the alleged perpetrator (AP) financially exploited residents when the AP took narcotic medication from three different residents.

**Investigative Findings and Conclusion:**
Financial exploitation was substantiated. The alleged perpetrator was responsible for the maltreatment. The AP diverted controlled substances from three residents by signing out the controlled substance medications prescribed to the residents, which the residents had not requested, and did not administer the medication to the resident.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted law enforcement and police report was requested. The investigation included a review of policies and procedures and staff training records. The AP's personnel file was reviewed. The resident's medical records were reviewed.

Resident #1 had a history of arthritis. Resident #1 was independent with most activities of daily living and received services with medication set up, bathing assist, housekeeping, and laundry. Assessments indicated she was alert and oriented and a reliable reporter. Nursing staff set up Resident #1's medications and she administered her own medications, including Tylenol, without any reminders. Resident #1 had a doctor's order for the narcotic medication, Norco, to be given as needed for pain. According to the incident report, Resident #1 stated she had only requested the stronger pain narcotic one time. Records indicated the AP signed out 48 doses (48 tablets), given as needed, of the Norco for Resident #1 in the narcotic record, but only documented 34 of the doses in the resident's electronic medication record.

Resident #2 had a history of knee and hip pain. Resident #2 was independent with most activities of daily living and received services for medication set up, bathing, housekeeping, and laundry. Resident #2 had a doctor's order for the opioid pain medication, tramadol, to be given as needed for pain. According to the incident report, Resident #2 stated that he did not have an increase in pain and did not request extra pain medication. The incident report indicated the AP stated she had given it several times for his knee and hip pain, although he did not ask for it, nor did the AP communicate that Resident #2 had increased pain to nursing or hospice. Narcotic records indicated the AP signed out 48 doses (a total of 96 tablets), given as needed, of the tramadol to Resident #2 but only documented 26 of the doses in the resident's electronic medication record.

Resident #3 had a history of osteoarthritis of the knee. Resident #3 received services for medication administration, bathing assist, housekeeping, and laundry. Resident #3's nursing assessment indicated she was mostly independent and requested additional pain medication if other attempts at relief did not work. Resident #3 had scheduled and an as needed doctor's orders for the opioid pain medication, tramadol. Incident reports indicated Resident #3 was interviewed and asked if she had requested extra doses of tramadol for pain in addition to her scheduled doses. Resident #3 responded that only one time did she request the extra dose. Resident #3 was able to describe what medications she took and what they were for. Narcotic records indicated the AP signed out 33 doses, given as needed, in addition to the scheduled doses of the tramadol to Resident #3 but only documented 23 of the doses in the electronic medication record.

Unlicensed staff whose duties included administering medications were interviewed. One staff stated that the AP signed out a higher number of as needed narcotic medications for residents than did other staff. A second staff person who was interviewed stated she knew her residents well and they had not complained of pain or requested additional pain medication when she worked. Both staff brought their concerns to management.

During interview, the registered nurse (RN) stated that the AP had been signing out pain medications to residents who did not typically request additional medication for pain. The RN stated that after closer inspection of medication and narcotic records, the AP consistently signed out more narcotic medication to three residents. The RN interviewed all three residents

and concluded that they had not asked for or received the additional pain medication. She stated it is a two-step sign out process and the AP signed out the medications in the narcotic book but did not always sign the medication out of the resident's electronic medication record.

During interview with this investigator, Resident #1 and Resident #3 stated that although they had pain, they had not requested or received additional pain medication on a routine basis. Family members were interviewed and corroborated the information that the residents would rarely express need for additional pain medication.

In a written statement provided to this investigator, the AP stated that when she arrived for work one day, the director of nursing and the administrator informed her she was being terminated based on her failure to document 46 narcotics in the EMAR (electronic medication record) for three residents and was not allowed to give a full statement. She told them that they were documented in the narcotic log, and some were documented in the 24-hour report as well and apologized for not documenting in the EMAR and stated that she had forgotten to document there. The AP declined to answer further questions.

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: …
(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**: Yes. Two residents were interviewed, one resident was deceased.
**Family/Responsible Parties interviewed**: Yes.
**Alleged Perpetrator interviewed**: The AP declined an interview but provided a written statement.

**Action taken by facility:**
The narcotic sign out and administration procedure was reviewed with all staff who administer medications. The facility made an addition to the procedure which included that all staff must call the RN prior to giving any narcotics that are ordered "as needed."
The AP is no longer employed by the facility.

**Action taken by the Minnesota Department of Health:**
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Minnesota Board of Pharmacy
Rice County Attorney
Faribault City Attorney
Faribault Police Department

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30786 | A. BUILDING: _____ B. WING _____ | C 03/30/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FARIBAULT SENIOR LIVING | 843 FARIBAULT ROAD FARIBAULT, MN 55021 |

| (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<br><br>Initial comments<br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL30786002C/#HL30786001M<br><br>On March 30, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 79 clients receiving services under the provider's Assisted Living with Dementia Care license.<br><br>The following correction order is issued issued for #HL30786002C/#HL30786001M, 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 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment | 02360 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 02360 | Continued From page 1<br><br>Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interviews and document review, the facility failed to ensure three of three residents reviewed (R1, R2, R3) were free from maltreatment. R1, R2, R3 were financially exploited.<br><br>Findings include:<br><br>On April 15, 2022, the Minnesota Department of Health (MDH) issued a determination that financial exploitation occurred, and that an individual staff person was responsible 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. | |