Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL316757166M
Compliance #: HL316753536C

Date Concluded: December 12, 2023

Name, Address, and County of Licensee Investigated:
Blaine White Pines II
12402 Jamestown Street NE
Blaine, MN 55449
Anoka County

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

Evaluator's Name: Deb Schillinger RN
Special Investigator
Paul Spencer RN
Special Investigator

Finding: Substantiated, individual responsibility

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) financially exploited resident #1 and resident #2 when the AP diverted their narcotic medications.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The investigation identified a consistent discrepancy of the AP signing out oxycodone in resident #1 and resident #2's handwritten narcotic book and each resident's electronic medical record (EMAR). Additionally, multiple unlicensed caregivers, the AP's co-workers, identified handwritten entries of their names they identified as forgeries for both resident #1 and #2. A review of the documents identified a pattern indicating the AP had access to resident #1 and resident #2's narcotic book at times consistent with when forgeries occurred.

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 individual narcotic records, resident medical records, facility policies and procedures, internal investigations, staff payroll, personnel records, and training records. Also, the investigator observed staff administering medications and interactions with residents.

A facility internal investigation indicated unlicensed caregivers raised concerns someone had forged their signatures on the individual narcotic record (narcotic book) and removed oxycodone under their names, which prompted the facility administration to investigate. The facility contacted several unlicensed caregivers for assistance with the investigation including the AP who declined to cooperate with the facility's investigation.

Resident #1

Resident #1 resided in an assisted living memory care unit with diagnoses including traumatic brain injury and bipolar disorder. The residents service plan included assistance with medication management and administration. Resident #1's orders for pain management included oxycodone 5 milligram (mg) every four hours as needed for complaints of pain. Resident #1 lived on the first floor of the facility.

During the investigation resident #1's narcotic book pages and EMAR were compared covering a time span of approximately two months, which included four pages from the narcotic book. Each of the narcotic book pages had room for 30 entries, which coincides with 30 oxycodone pills per pill card.

The first page in resident #1's narcotic book indicated the AP signed out and removed a narcotic from the resident's supply 14 times. The EMAR for the same time indicated the AP documented administering the same narcotic seven times.

The second page in resident #1's narcotic book indicated the AP signed out and removed a narcotic from the resident's supply 14 times. The EMAR for the same time indicated the AP documented administering the same narcotic nine times.

The third page in resident #1's narcotic book indicated the AP signed out and removed a narcotic from the resident's supply 16 times. The EMAR for the same time indicated the AP documented administering the same narcotic seven times.

The fourth page in resident #1's narcotic book indicated the AP signed out and removed a narcotic from the resident's supply 23 times. The EMAR for the same time indicated the AP documented administering the same narcotic approximately three times.

The facility's internal investigation indicated the facility reviewed resident #1's narcotic book on the 10th day of the month. The resident's narcotic book indicated the AP had signed out the last pill and filled out the last entry on the fourth page of resident #1's narcotic book at 11:00 a.m. on the 10th. However, this entry was identified by the facility at 8:00 a.m. on the 10th thus three hours prior to the documented time.

Resident #1's narcotic book indicated the AP signed out the last five oxycodone pills with four of the five dated the 9th of the month, one of which the AP documented removing from the resident's supply was dated for the 9th at 2:00 p.m. The fifth and final oxycodone pill the AP documented removing from the resident's supply was dated for the 10th at 11:00 a.m.

A review of the payroll records indicated the AP worked the 9th but was off the payroll at 11:45 a.m. The AP was not on the schedule or the facility payroll on the 10th.

Resident #2

Resident #2 resided in an assisted living memory care unit. The resident's diagnoses included dementia with behavioral disturbance and mild cognitive impairment. The resident's service plan included assistance with medication management and administration. Resident #2 had orders for oxycodone 5 mg, scheduled two times per day and an additional oxycodone 5 mg as needed (PRN) for complaints of increased pain one time per day. Resident #2 lived on the second floor of the facility.

During the investigation resident #2's narcotic book pages and EMAR were compared for as needed dosage that could be given one time per day, and EMAR were compared covering a time of approximately two months, which included two pages from the narcotic book. Each of the narcotic book pages has room for 30 entries, which coincides with 30 oxycodone pills per pill card.

The first page in resident #2's narcotic book indicated the AP signed out and removed a narcotic from the resident's supply 15 times. The EMAR for the same time indicated the AP documented administering the same narcotic four times.

The second page in resident #2's narcotic book indicated the AP signed out and removed a narcotic from the resident's supply 10 times. The EMAR for the same time indicated the AP documented administering the same narcotic two times.

Resident #2's narcotic book indicated the AP signed out the last oxycodone pill on the 9th of the month. The final oxycodone pill the AP documented removing from the resident's supply was dated for the 9th at 2:00 p.m.

A review of the payroll records indicated the AP worked the 9th but was off the payroll at 11:45 a.m.

Claims of Forgery

Resident #1 Narcotic Book

During an interview unlicensed caregiver #1 stated her name had been forged in resident #1's narcotic book

An example identified by unlicensed caregiver #1 was found on resident #1's third narcotic page.

Resident #1's narcotic book indicated unlicensed caregiver #1 removed and oxycodone twice. The facility's payroll records showed unlicensed caregiver #1 was present that day and shift the 26th of the month. However, unlicensed caregiver #1 identified the second of the two entries as a handwritten forgery of her signature for later that same day and shift.

Resident #1's EMAR indicated unlicensed caregiver #1 documented the first oxycodone as administered, which was consistent with her statement she gave the first dose that day. A review of the EMAR indicated the second dose of oxycodone attributed to her in the narcotic book was not documented as administered in the EMAR, which was also consistent with her statement she did not give the second dose that day.

The entry identified by unlicensed caregiver #1 as a forgery included date, time, and name.

The facility's payroll records indicated the AP worked the following day the 27th of the month.

Resident #1's narcotic book and EMAR indicated no other oxycodone doses were removed or administered until the 27th when the facility payroll records indicated the AP worked.

After the entry unlicensed caregiver #1 identified as a forgery, the next four handwritten entries of removing resident #1's oxycodone were entered by the AP. Of those four, one was documented in the EMAR as administered by the AP.

The final entry on the page was dated for the 28th, which was a day the AP worked but on a different floor. Resident #1's EMAR did not indicate any oxycodone was documented for resident #1 on the 28th day of the month.

Resident #2 Narcotic Book

During the same interview cited above, unlicensed caregiver #1 stated her name was forged in resident #2's narcotic book.

Two examples identified by unlicensed caregiver #1 were on the second page of resident #2's narcotic book. The first was dated the 21st of the month and was the first entry on the page. The second example was dated the 27th of the month and was the fourth entry on the page.

During a separate interview unlicensed caregiver #2 stated her name was forged on the second page resident #2's narcotic book. The entry she identified was the second entry on the page and dated the 25th of the month.

During a separate interview unlicensed caregiver #3 stated her name was forged in resident #2's narcotic book on the second page. The entry she identified was the third entry and dated the 26th of the month.

Each of the entries identified by caregivers #1, #2, and #3 as forgeries included date, time, and name.

A review of resident #2's EMAR indicated neither unlicensed caregiver #1, #2, nor #3 documented administration of the oxycodone in the EMAR, which was consistent with their statements.

The facility's payroll records indicated the AP did not work from the 16th of the month through the 26th and returned on the 27th and worked on a different floor then resident #2. The same document indicated she did work resident #2's floor on the 28th of the month and had access to resident #2's narcotic book.

The first page of resident #2's narcotic book indicated the AP signed out on the last two entries on that page on the 15th of the month. The resident's EMAR indicated the AP documented administration of one of these oxycodone but not the other.

Resident #'2's EMAR indicated no employee documented administering the resident's as needed oxycodone from the 15th until the 28th when the AP did so.

After the first four entries claimed to be forges by unlicensed caregivers #1, #2, and #3, the fifth and sixth entry indicated the AP removed oxycodone from resident #2's as needed supply. The EMAR indicated the AP documented administration of one in resident #2's EMAR on the 28th.

The facility's schedule indicated the AP worked some days on the first floor, while other days on the second floor. The facility schedule indicated the AP worked first floor on the 27th day of the month, while she worked on second floor on the 28th day of the month, which is consistent with the documentation in each resident's EMAR.

The facility investigation indicated more than five unlicensed caregivers reported handwritten entries in their names that they identified as forgeries. The same documents did not indicate the AP was among those who stated her name had been forged. The same documents indicated the facility reached out to the AP by both telephone and text message, however the AP declined to participate in the investigation, nor did she return to work at the facility.

During an interview, the AP denied taking narcotic medications or falsification of signatures. The AP stated the facility computers were sometimes down and she could have forgotten to document medication administration.

In conclusion, the Minnesota Department of Health determined 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:
(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.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Completed internal investigation and terminated employment for AP. The facility established an audit system to ensure the documentation of the EMAR and the narcotic books were reconciled. The facility reviewed the residents with narcotic and/or other controlled substances and reduced the number of such medications in use in the facility. No further discrepancies were identified after the AP’s employment was discontinued.

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.

You may also call 651-201-4200 to receive a copy via mail or email.

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
Anoka County Attorney
Blaine City Attorney
Blaine Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31675	A. BUILDING: _____ B. WING _____	C 09/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAINE WHITE PINE II	12402 JAMESTOWN STREET NE BLAINE, MN 55449

(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****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482/144G.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: HL316757166M/HL316753536C On September 5, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. The following correction order is issued/orders are issued for HL316757166M/HL316753536C, tag identification 2360.	0 000		
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 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. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two resident(s) reviewed (R1 and R2) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction required.	