Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL32587003M, HL32587005M, HL32587007M

Date Concluded: June 6, 2022

Compliance #: HL32587004C, HL32587006C, HL32587008C

Name, Address, and County of Licensee Investigated:
The Sanctuary at West St. Paul
1746 Oakdale Avenue
West St. Paul, MN 55118
Ramsey County

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

Evaluator's Name:
Maerin Renee, 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 that the alleged perpetrator (AP) financially exploited three residents when the AP took narcotic medication from three different residents.

Investigative Findings and Conclusion:
Financial exploitation was substantiated. The facility was responsible for the maltreatment. Three residents, R1, R2, and R3, were missing narcotic medications. The facility completed an investigation, and no AP could be identified due to the facility's lack of procedural oversight that enabled the diversion of narcotic medications over the course of several months.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The residents medical record, facility medication process,

employee records, and facility policy and procedures were reviewed. In addition, the investigator contacted law enforcement.

Resident #1 (R1) had diagnoses that included dementia and high blood pressure. The resident was independent with activities, but received assistance with bathing, dressing, grooming, housekeeping, laundry, and medication management. R1 had a prescribed order for the narcotic medication hydrocodone with acetaminophen to be given three times a day for pain.

Per internal investigation documents, three cards with thirty (30) tablets of hydrocodone with acetaminophen for R1 were logged into the narcotic logbook by the AP. Only two cards were eventually sent to the medication cart, leaving a total of 30 tablets of R1's hydrocodone with acetaminophen missing. The missing card was documented as having been sent to the med cart on a date the AP was not scheduled to work. There was no signature to indicate which staff member allegedly transferred the medication card to the medication cart, nor was the time of the alleged transfer indicated.

On another occasion, four cards each with five tablets of hydrocodone with acetaminophen for R1 were logged into the narcotic logbook by the AP. However, the AP logged only one card on the index of the logbook instead of four. Three cards were documented as having been sent to the medication cart, but none of the three cards were logged as having arrived at the medication cart. This left a total of twenty (20) missing tablets of hydrocodone with acetaminophen. All documents were signed with illegible signatures, and on two of the dates the AP was not scheduled to work. Times were documented on only two of the pages, but they did not indicate whether they were A.M. or P.M.

On a third occasion, three cards each with thirty (30) tablets of hydrocodone with acetaminophen for R1 were logged into the narcotic logbook. Two of the cards were documented as having been sent to the medication cart, but they were not documented as having arrived at the medication cart. This left a total of sixty (60) missing tablets of hydrocodone with acetaminophen. Two nurses, one being the AP, were scheduled to work both evenings of the alleged medication transfers, however no times were documented in the logbook, only dates with illegible signatures.

Resident #2 (R2) had diagnoses that included osteoarthritis. R2 was independent with activities, but received assistance with bathing, dressing, housekeeping, laundry, and medication management. R2 had a prescribed order for the narcotic medication hydrocodone with acetaminophen to be given every four hours as needed for pain.

Per facility documentation, six cards each with thirty (30) tablets of hydrocodone with acetaminophen were received by the AP and logged into the narcotic record book by a nurse. One card was sent to the medication cart, but the original date was overwritten by an unidentified person to indicate the card was sent to the cart a week earlier than originally written. Another card was sent to the medication cart, with dates similarly falsified,

documented by the AP. All the other medication cards were documented as “sent to cart” with falsified dates and illegible signatures. The total number of missing narcotic medication tablets was 120 tablets. Upon review of the facility documentation, narcotic log dates were scribbled out and rewritten, and signatures were illegible or completely missing. It could not be determined who logged receipt of medication deliveries or documented that the cards were sent to the medication cart.

Resident #3 (R3) had diagnoses that included generalized muscle weakness. The resident was independent with activities, but received assistance with bathing, housekeeping, laundry, and medication management. R3 had a prescribed order for the narcotic medication oxycodone with acetaminophen to be given at bedtime for pain. He also had a prescribed order for the narcotic medication oxycodone to be given every six hours as needed for pain. When interviewed, R3 said he remembered one time when he requested oxycodone with acetaminophen for pain but received acetaminophen after the staff member told him he was out of oxycodone with acetaminophen. However, when reviewed, documentation did not indicate evidence of this occurrence.

Per facility documentation, one card with fifteen (15) tablets of oxycodone for R3 was logged into the narcotic record book by the AP. Documentation in the logbook indicated the card was sent to the medication cart, but the card never arrived at the cart. The total number of missing oxycodone tablets was fifteen (15). Upon review of this documentation, both signatures were illegible, so it could not be determined whether it was the AP who either logged receipt of the delivery or documented that the card was sent to the medication cart.

When interviewed, a facility unlicensed staff member who was trained to pass medications said she noticed R1 was low on oxycodone (narcotic pain medication), so she requested another card for him from the nurse on duty. The nurse could not find another card of oxycodone for R1 although the narcotic medication logbook indicated he should have had more medication left. After searching, the director of health services was notified, and that’s when the investigation into the missing oxycodone began.

When interviewed, the facility nurse stated R1’s missing medication card initiated further investigation, where it was discovered that two other residents were missing narcotic pain medications. Staff looked through the charts, narcotic medication logbooks, and medication administration records (MARs), counts and signatures didn’t add up. The nurse stated the AP was the consistent person scheduled in conjunction with noted discrepancies.

During an interview, facility management stated she was notified of missing narcotic medication and an investigation was started. It was discovered several cards of narcotic pain medication for three different residents were logged into the receiving narcotic logbook upon delivery, and then later documented as being transferred to the medication carts. Although several cards of narcotic pain medication were documented as transferred from the medication storage room to the med carts, the narcotic logbooks lacked documentation that the

medication cards had been received at the carts. The narcotic medications were not in the medication carts and could not be located. Management stated she requested handwriting analysis from the police department because many of the signatures on the facility narcotic tracking system were unfamiliar, but the request was denied. Management stated they could not say who diverted R1, R2, and R3's narcotic medications with complete certainty, but she "felt in her gut" that it was the AP.

During an interview, the AP said the narcotic logbooks in the medication storage room and at the med carts were separate logbooks, and counted separately, but not reconciled with each other, so discrepancies took a while to be noticed. The AP said one of her entries was pointed out to her, but she said it looked like someone else had written over the number she originally documented. The AP denied writing false entries into the logbooks and denied the allegation that she diverted R1, R2, or R3's narcotic medications.

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: Yes, two residents were interviewed, one resident was in the hospital.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility initiated an internal investigation, re-educated staff regarding medication administration and documentation, and changed documentation procedures to include the requirement of two staff members always signing off on narcotic medications.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html
If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.
You may also call 651-201-4890 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney
West St. Paul City Attorney
West St. Paul Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32587	A. BUILDING: _____ B. WING _____	C 05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT WEST ST PAUL	1746 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

(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 WITH DEMENTIA CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 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: #HL32587003M/#HL32587004C #HL32587005M/#HL32587006C #HL32587007M/#HL32587008C On May 19, 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 128 residents receiving services under the provider's Assisted Living with dementia care license. The following correction order is issued for #HL32587003M/#HL32587004C, #HL32587005M/#HL32587006C, and #HL32587007M/#HL32587008C, 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. 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 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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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: Based on interviews and document review, the facility failed to ensure 3 of 3 residents (R1, R2, and R3), were free from maltreatment. R1, R2, and R3 were financially exploited. Findings include: On May 19, 2022, the Minnesota Department of Health (MDH) issued a determination that financial exploitation occurred, and that the facility 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.	