Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL329445303M
Compliance #: HL329449095C

Date Concluded: October 22, 2023

Name, Address, and County of Licensee Investigated:
Generations Home Care INC
405 2nd Ave S
Waite Park, MN 56387
Stearns

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: **Substantiated, individual responsibility**

Nature of the 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 when the AP diverted the resident's controlled substance medications.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP, an unlicensed caregiver, was responsible for the maltreatment. Although the AP did not have medication pass responsibilities at the time, the AP accessed the resident's controlled substance medications.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff members. The investigator contacted the resident and the resident's family member. The investigation included review of resident's records, the AP's personnel record, facility's policies and procedures, and incident reports. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living facility. The resident's diagnoses include bipolar and personality disorder. The resident's service plan included redirection regarding medication times and administration.

The facility's internal investigation indicated the AP was scheduled to work from 3 pm to 11 pm on Saturday. Unlicensed caregiver #1, who was also working that same day, was scheduled from 3 p.m. to 9 p.m. and was responsible for passing medication. The last medication count of controlled substances was conducted at 3 pm, and it was accurate with no discrepancies. The same documents indicated video surveillance footage, around 9 p.m., showed the AP accessed the medication cabinet, took the medication bin, closed the cabinet, and put her hand in the pocket of her sweatshirt.

The facility's internal investigation further indicated a third employee, unlicensed caregiver #2, arrived at 11 p.m. and initialed the medication count book without conducting the actual count. The next morning at change of shift two other employees, unlicensed caregivers #3 and #4, joined unlicensed caregiver #2 for the medication count, and it they found the medication count was incorrect for the resident's prescribed benzodiazepine (clonazepam). The video surveillance footage showed that unlicensed caregiver #2 did not access the medication cabinet during her shift.

During an interview, unlicensed caregiver #2 confirmed she worked the night shift that weekend. She admitted she was supposed to conduct the medication count with the AP but did not. At the time she was occupied assisting the resident, and the AP performed the count independently. Unlicensed caregiver #2 explained she trusted the AP, so she did not feel the need to double-check the count. When unlicensed caregivers #3 and #4 arrived in the morning and conducted the count with unlicensed caregiver #2, they found the medication count to be to be incorrect. Unlicensed caregiver #3 promptly reported the discrepancy to the management team.

During an interview, unlicensed caregiver #3 stated the AP had a history of incidents where she claimed the medication rolled away or dropped in the garbage. To address this recurring issue, the facility installed surveillance cameras and unlicensed caregivers were instructed to perform the medication count at shift changes. Unlicensed caregiver #3 stated since the medication was scheduled to be administered at 8 p.m., there was no valid reason for the AP to access the locked medication cabinet at 9 p.m.

During an interview, a management team member acknowledged being informed of the incident by unlicensed caregiver #3. The management team member stated she initiated the investigation, reported it to the police, and reviewed the surveillance footage. She interviewed all the unlicensed caregivers who worked that day. During these interviews, unlicensed caregiver #2 admitted to signing the medication count book without actually performing the medication count when she started her shift. The management team member stated unlicensed

caregivers did not administer any medications during the night shift. However, although the facility had removed the AP from medication administration duties prior to this incident, the video surveillance showed the AP accessing the locked medication bin. Since the AP had no medication pass duties, there was no reason for her to access the medications. She stated the footage showed her accessing the locked medication bin, picking it up, going through it with both hands, and then closing the cabinet while putting her hand in her sweatshirt. The management member stated that when she interviewed the AP, the AP cried and did not provide any verbal response.

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:
(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
Family/Responsible Party interviewed: No, attempts to interview were unsuccessful
Alleged Perpetrator interviewed: No, attempts to interview were unsuccessful

Action taken by facility:
The internal investigation was initiated, and the incident was reported to the police department. Caregiver #2 received education for not counting the medication at change of shift. The AP is no longer employed at 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.

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
Stearns County Attorney
Waite Park City Attorney
Waite Park Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32944	A. BUILDING: _____ B. WING _____	C 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	705 2ND AVENUE SOUTH WAITE PARK, MN 56387

(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 On October 2, 2023, the Minnesota Department of Health initiated an investigation of complaint HL329449095C/ HL329445303M. The following correction order is issued, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment 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 one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual alleged perpetrator 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 is required for this tag.	