Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL33599001M
Compliance #: HL33599002C

Date Concluded: March 22, 2022

Name, Address, and County of Licensee Investigated:
Amira Choice Plymouth
18405 Old Rockford Road
Plymouth, MN 55446
Hennepin County

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

Evaluator's Name:
Maerin Renee, RN, Special Investigator
James Larson, 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(s):
It is alleged the alleged perpetrator (AP) financially exploited a resident when she took 16 tablets of oxycodone from the resident.

Investigative Findings and Conclusion:
Financial exploitation was substantiated. Based on a preponderance of evidence the AP was responsible for the maltreatment. The AP failed to document destruction of narcotic medications or documented destruction of narcotic medications without prescriber orders. On the day in question, the AP had unwitnessed access to the medication cart containing narcotic medication.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigators reviewed resident medication records,

narcotic logbooks, employee records, and facility policies and procedures. In addition, law enforcement was contacted.

The resident's diagnoses included spinal stenosis, paraplegia, and chronic pain. The resident received services including bathing, dressing, grooming, meal assistance, repositioning, transfers, safety checks, medication management, laundry, and housekeeping.

During an interview, the executive director (ED) said she and the director of health services (DHS) initiated an internal investigation after staff reported a bubble pack containing 16 tablets of the resident's oxycodone was missing. ED said at shift change that morning, two unlicensed personnel (ULP-D and ULP-E) completed the narcotic medication count, and all narcotic medications were accounted for at that time. The narcotic logbook indicated a partially opened tamper-resistant card with 16 oxycodone tablets was confirmed and inventoried at morning shift change. Later that day, around lunch time, the resident requested her oxycodone. ULP-C planned to administer the oxycodone to the resident when she noticed the bubble pack containing 16 tablets of oxycodone was missing. When interviewed, ULP-C stated that a new unopened 30 count pack was the only card of the resident's oxycodone present. After an extensive search, the bubble pack was not found, and ULP-C reported the discrepancy to DHS.

ED stated during that shift three people had access to the medication cart: ULP-C, ULP-D, and the AP. During the internal investigation, ED and DHS determined the AP was not following proper procedures for medication management. ED and DHS brought their immediate concerns to the AP. As the internal investigation continued, ED said she and DHS discovered the AP documented unnecessarily destroyed prescribed narcotic medications for several residents. The facility's internal investigation did not indicate specific residents or narcotic medications.

ED stated as she and DHS reviewed documentation, they found the AP would destroy medication within 24 hours of getting a new order for the medication and there were also resident medications she destroyed without proper discontinuation orders. ULP-G stated she felt singled out by AP because the AP chose her to witness destruction of narcotic medications frequently, rather than another RN as required by facility policy. The facility's internal investigation indicated 99% of narcotic medications were destroyed by the AP, and 80% of narcotic medication destruction was witnessed by ULP-G. Per the internal investigation, ULP-G stated she couldn't confirm that she witnessed every pill being destroyed because frequently the medication was already removed from the tamper resistant packaging laying and the tablets were on the desk. ULP-G stated she sometimes felt hesitant to sign for medication destruction and she shared her concerns with other staff, however, the AP was a supervisor.

As the internal investigation continued, ED stated they reviewed all the facility narcotic books but were not able to locate two of the books. ED stated the completed narcotic logbooks were kept in a double-locked system in the DHS office, but the missing logbooks were not there. The AP told ED and DHS that she had placed the missing logbooks in the DHS office. During the search for the missing narcotic logbooks, ED and DHS found two locked drawers in the AP's

office that contained a variety of medications including supplements, scheduled medications, and narcotic medications. The narcotic medications found in the drawers included tramadol, morphine sulfate, oxycodone, morphine/lidocaine, and lorazepam from different residents of the facility. When asked about the medications in her desk drawers, the AP said she was hurrying through her job and didn't do anything wrong.

During an interview, DHS stated on the day of the incident the narcotic medication count was done at morning shift change and was accurate. A few hours later the residents Oxycodone could not be located. After ULP-C reported the missing oxycodone, DHS began an internal investigation by reviewing the current narcotic logbook, medication handling process, and drug disposition book. DHS found, among other things, that documentation the AP was responsible for was missing, as well as narcotic medications that were improperly documented as destroyed with no orders to discontinue the medications, and multiple medications improperly stored in the AP desk drawers, including narcotic medications.

DHS stated the internal investigation indicated on the day in question the AP asked ULP-D to unlock the medication cart for her so she could complete medication checks and a resident's medication set up. Per the internal investigation, after ULP-D unlocked the medication cart the AP brought the cart to a different section of the facility to complete the medication checks. The AP reported that once she completed the medication checks, she locked the medication cart and left the area. The AP had access to the narcotic box key for the narcotic box located within the medication cart. DHS stated the AP documented destruction of narcotic medications that residents weren't using or requesting but still had a current physician order for. The AP did admit that she had signed training confirmation documentation and that she needed to follow policy and procedures appropriately, although went on to state that she didn't always have time to properly document according to the facility policy and procedures.

When interviewed, ULP-C said ULP-D asked her to help with administering medication for the resident later in the morning the day of the incident. ULP-D gave ULP-C the keys to the medication cart. Upon unlocking the medication cart and then unlocking the narcotic medication box, ULP-C noticed the resident had 16 Oxycodone missing. The narcotic logbook stated a partially opened tamper-resistant card with 16 Oxycodone were inventoried at morning shift change that day. ULP-C stated when she opened the narcotic medication box, a new unopened 30-count pack was the only card of oxycodone present for the resident. The discrepancy was reported to DHS.

Facility documents indicated the AP destroyed approximately 82 tablets of the resident's oxycodone and documented the reason being the oxycodone was discontinued. However, per facility documentation, the medication was not discontinued, but the dose was changed. The narcotic medication logbook that recorded the counts of narcotic medications indicated on the day in question, ULP-D and ULP-E verified the resident's Oxycodone count of 16 tablets at shift change. A line written in ink crossed the page where the 16 Oxycodone were originally documented and there was no further documentation on the page. A record of destruction for

the resident's oxycontin indicated revealed the AP destroyed 49 tablets of the resident's oxycodone in the span of two days. The three entries on the destruction log had no corresponding entries in the narcotic medication logbook.

When interviewed, the AP stated on the morning of the incident she asked ULP-D to unlock the medication cart so the AP could refill a medication reminder for a resident. ULP-D unlocked the medication cart and entered an apartment to assist a resident with cares. The AP stated she remained at the medication cart, set up the medication and locked the cart when she was finished. The AP said she didn't remember taking the cart to a different location, as reported in the facility internal investigation. The AP said she was aware of an extra key to access the narcotic medication box, but that she did not know where it was kept. The AP denied taking the missing oxycodone.

In conclusion, financial exploitation was substantiated.

"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

"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: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility completed an internal investigation, updated policies, and provided staff training regarding updated medication management procedures. 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.

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
Hennepin County Attorney
Plymouth City Attorney
Plymouth Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33599	A. BUILDING: _____ B. WING _____	C 03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIRA CHOICE PLYMOUTH	**18405 OLD ROCKFORD ROAD PLYMOUTH, MN 55446**

(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 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: #HL33599002C/#H33599001M On March 1, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order was issued. At the time of the complaint investigation, there were 93 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL33599002C/#HL33599001M, 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33599	A. BUILDING: _____ B. WING _____	C 03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIRA CHOICE PLYMOUTH	**18405 OLD ROCKFORD ROAD PLYMOUTH, MN 55446**

(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
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 1 of 1 resident, R1, reviewed was free from maltreatment. The resident was neglected. Findings include: On March 1, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect 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.	