

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL347126944M  
**Compliance #:** HL347123222C

**Date Concluded:** January 24, 2024

## **Name, Address, and County of Licensee**

### **Investigated:**

Millers Landing Senior Living  
155 S 5<sup>th</sup> Ave  
Minneapolis MN 55401  
Hennepin County

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

**Evaluator's Name:** Maggie Regnier  
Special Investigator

**Finding:** Inconclusive

### **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 residents when controlled medications from discharged or deceased residents went missing from the nurse's office.

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined financial exploitation was inconclusive. While it was true three residents' controlled medications went missing from the nurse's office, it could not be determined who took the medications. The investigation found at least three other staff members besides the AP had access to these medications and the facility system for tracking narcotics for discharged or deceased residents was insufficient. The facility was issued a compliance correction order to address the medication storage concerns.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of facility records, resident

records, policies and procedures. Also, the investigator observed facility layout including nursing and leadership offices, staff interactions with other staff, residents, and visitors.

All three residents resided in an assisted living facility with memory care.

Resident #1 diagnoses included chronic leukemia, kidney failure, and heart failure. The residents service plan indicated he was on hospice and needed assistance with bathing, toileting, medications, and meals.

Resident #2's diagnoses included chronic heart disease, chronic obstructive pulmonary disease, cerebral infarction (stroke), with hemiplegia (paralysis of one side of the body) and diabetes. The residents service plan indicated the resident was on hospice and needed assistance with bathing, toileting, medications, and meals.

Resident #3's diagnosis included bipolar disorder and chronic pain. The residents service plan indicated the resident received help with dressing, bathing, medication administration and behavior management.

The facility's internal investigation indicated a facility registered nurse (RN) was setting up the weekly Medi planner for resident #3 when she realized a full card of tramadol, a strong medication used for pain, was missing. The missing would have contained 30 pills. The RN notified the facility leadership of this missing medication and a search for the missing medications was undertaken but the tramadol was not found.

During the search, the facility discovered that controlled medications for two discharged residents (resident #1 and resident #2) that had been stored in the nurse's office were also missing. The facility found resident #1 was missing 7 morphine tablets and resident 2 was missing 1 oxycodone and 16 Ativan pills. The facility had bagged up these residents' medications for family to pick up or to be given to the hospice service when these residents had been discharged or deceased weeks earlier. It was not determined when these medications went missing.

During an interview, a member of the facility management stated they had reason to believe one nurse in particular may have taken the medications. However, the manager stated that three nurses plus the assisted living director all had keys to the office where the medications were stored and therefore had access to these medications. The manager also acknowledged the facility was unable to pinpoint a day when the medications went missing.

During an interview an interview, the RN stated it was the practice to bag up all medications when a resident was discharged and then give to the family. Once these medications are bagged, they do not count the meds or check them daily. The RN stated the bag was in a locked area but acknowledged that the medications were not tracked daily.

An internal audit was done on all the medication carts and no other medications were missing.

Review of resident #1 records indicated the resident took the medication for pain while on hospice care. The medication went missing after the resident had passed away.

Review of resident #2 records indicated the resident took the medications for pain and agitation while on hospice. The medication went missing after the resident passed away.

Review of resident #3 records indicated the resident took the medications for pain. The facility had more of the medication and the resident was able to continue taking the medication uninterrupted.

In conclusion, the Minnesota Department of Health determined financial exploitation was inconclusive.

**Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.**

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

**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:** no, deceased

**Family/Responsible Party interviewed:** unsuccessful

**Alleged Perpetrator interviewed:** unsuccessful

**Action taken by facility:**

The AP is no longer employed by the facility.

**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 651-201-4200 to receive a copy via mail or email

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Board of Nursing

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34712</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/05/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MILLERS LANDING SENIOR LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>155 5TH AVENUE SOUTH MINNEAPOLIS, MN 55401</b>
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(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	<p><b>Initial Comments</b></p> <p>*****ATTENTION*****</p> <p><b>HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b></p> <p>HL347123222C/HL347126944M &amp; HL347128324M/HL347125502C</p> <p>On December 5, 2023, 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 68 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued/orders are issued for #HL347123222C/#HL347126944M, tag identification 1910.</p> <p>No orders are issued for HL347128324M/HL347125502C.</p>	0 000	<p>Assisted Living Provider 144G. Minnesota Department of Health is documenting the State 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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Minnesota Department of Health

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01910	Continued From page 1	01910		
01910 SS=F	<p><b>144G.71 Subd. 22 Disposition of medications</b></p> <p>(a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.</p> <p>(b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.</p> <p>(c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include all the required content for 2 of 2 discharged residents (R1 and R2) plus one current resident (R3).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all</p>	01910		

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01910	<p>Continued From page 2 of the residents).</p> <p>The findings include:</p> <p>R1 was discharged from the licensee on May 30, 2023. R1 progress note dated May 31, 2023 indicated his medications would be bagged up for his nephew to pick up. His medications included 7 - 5 milligram (mg) morphine tablets.</p> <p>R2 deceased the facility May 30, 2023. A document titled Discharge summary dated May 31, 2023 indicated R2's medication were destroyed via "destroyer". R2's medication included 1 oxycodone tablet and 16 Ativan tablets.</p> <p>An internal facility investigation dated June 15, 2023, registered nurse (RN-C) was setting up a Medi planner for R3 when she noticed a sheet of 30 tablets of Tramadol was missing. She notified the licensed assisted living director (LALD-A). They discovered that medication for R2 and R3 that had been stored locked in the office was missing narcotics. R1 was missing 7 5mg morphine tablets and R2 was missing the 1 oxycodone and 16 Ativan tablets. The same document indicated the facility determined controlled medications had been removed from multiple discharged residents' supply stored in the nurse's office.</p> <p>R1's and R2's record lacked a medication disposition record with required record to include:</p> <ul style="list-style-type: none"> <li>- medication's name;</li> <li>- strength;</li> <li>- prescription number as applicable;</li> <li>- quantity;</li> <li>- to whom the medications were given;</li> </ul>	01910		

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01910	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>- date of disposition; and</li> <li>- names of staff and other individuals involved in the disposition.</li> </ul> <p>During an interview on December 6, 2023, at 2:05 p.m., LALD-A stated it was the facility's practice to keep and store a discharged resident's medication to give to the family, this includes narcotics.</p> <p>During an interview on December 8, 2023 RN-C stated that it is the facility practice to bag up medications for discharged residents until a family can pick them up including narcotics.</p> <p>A policy titled, 7.23 Medication disposal, dated 8/1/2021, states that unused controlled substances remaining when the resident's medications are not managed by Millers Landing, the medications are expired, or the medication has been discontinued by the prescriber, must be disposed of in accordance with accepted practices of the Minnesota Board of Pharmacy. this policy also states that upon disposition, the facility must document in the resident's record the disposition of the expired medication including the medication's name, strength, prescription number if applicable, quantity, date of disposition, and names of staff (including a witness) and other individuals involved in the disposition. A copy of the destruction record will be kept on file at the facility of two (2) years.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01910		