Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL352301453M
Compliance #: HL352302902C

Date Concluded: October 25, 2022

Name, Address, and County of Licensee Investigated:
Urbana Place Senior Living
5601 94th Ave North
Brooklyn Park, MN 55443
Hennepin County

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

Evaluator's Name: Lena Gangestad
Christine Bluhm
Special Investigators

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.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) financially exploited the resident when the AP destroyed four tablets of 2.5 milligram (mg) morphine by crushing them between her fingers and threw the rest of the card which contained 26 tablets in the trash.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The alleged perpetrator (AP) was responsible for the maltreatment. The AP did not follow the facility protocol to destroy the controlled substance medication correctly claiming she used her fingers to crush four tablets and put the rest of the card which contained 26 tablets of morphine 2.5 milligram (mg) in the trash can at the nurse station.

The investigation included interviews with family member and facility staff members, including the director of nursing and nursing staff. The resident declined the interview due to health concern. The investigation included a review of facility incident reports, police report, the resident's records, and records of other residents who took narcotic medication. In addition, while on-site at the facility, the investigator checked the locked medication cabinet in other residents' apartment and observed no concerns.

The resident resided in an assisted living facility. The resident's diagnoses included lung cancer and cancer-related pain. The resident service plan indicated the resident was alert and oriented and required assistance with toileting. The same document indicated the resident managed her own medications, including pain medications.

The facility started an internal investigation and filed a police report. The facility suspended the AP pending investigation. The AP's employment file indicated the facility terminated the employee's employment.

During an interview, the AP stated the pharmacy delivered a card containing 30 tablets of morphine 2.5 mg solutabs on Friday. The AP stated she knew the resident was in the building but did not know which apartment she was in, so she just left it at the nurse's station. The AP came back to work in the evening the next Tuesday and saw the medications still there. She stated destroyed four tablets by crushing them between her fingers and threw the rest of the card which contained 26 tablets in the trash. She stated she did that to help the facility out of trouble because they did not have any policy about the destruction of controlled substance medication.

During an interview, the night nurse stated she spotted the top of a medication card that had been ripped off the bubble pack. She then discovered the card contained 26 tablets of morphine 2.5 mg placed inside an empty box of gloves in the garbage can. The night nurse stated she knew it belonged to a resident who self-administers her own medications as she had noticed it in the nursing office for a couple of days. She confirmed she did not look in the trash nor notice any crushed medications in the garbage can. The night nurse confirmed destruction of medication requires two nurses present per facility policy.

During an interview, director of nursing stated they could not find the crushed medication as the garbage can was emptied before she could search it.

The AP's employment file indicated the facility terminated the employee's employment.

In conclusion, the Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment.

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:
(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, the resident declined the interview.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility added a locked cabinet to securely store medications waiting to be delivered. The facility conducted facility-wide education regarding prompt delivery of medications to resident apartments and the destruction of medications including controlled substances. Additionally, the facility implemented a monthly audit system for medications stored in the nursing office.

A new residents log had been placed in the nursing office and shown to staff to ensure they were aware of where to look to review current residents list.

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
Brooklyn Park City Attorney
Minnesota Board of Executives for Long Term Services and Supports

Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35230	A. BUILDING: _____ B. WING _____	C 09/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANA PLACE SENIOR LIVING	5601 94TH AVENUE NORTH BROOKLYN PARK, MN 55443

(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: #HL352302902C/#HL352301453M #HL352302896C/#HL352301451M On September 13, 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 89 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL352302902C/#HL352301453M, tag identification 2360.	0 000	Assisted Living Provider 144G. 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.	

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02360	Continued From page 1	02360		
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: Based on observations, interviews, and document review, the facility failed to ensure one of three residents reviewed (R1) was free from maltreatment. R1 was financial exploited. Findings include: The Minnesota Department of Health (MDH) issued a determination that financial exploitation occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility.	02360	No plan of correction is required for tag 2360. Please refer to the public maltreatment report (report sent separately) for details.	