

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL389832602M
Compliance #: HL389834568C

Date Concluded: July 18, 2025

Name, Address, and County of Licensee

Investigated:

Personal Care Senior Living
3850 Jefferson Street Northeast
Columbia Heights, MN 55421
Anoka County

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

Evaluator's Name:

Maerin Renee, RN, 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), facility staff, financially exploited the resident when he stole the resident's narcotic pain medication for personal use.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined financial exploitation was inconclusive. The resident said she did not receive her pain medication (hydrocodone) one evening when the AP was working; and also stated there were multiple other times she did not receive her hydrocodone when she requested it. A nurse who reviewed video footage said she saw the AP ingest the resident's hydrocodone. An administrator who reviewed the same video footage said she did not see the AP ingest the hydrocodone. The video was not available for investigator review. It could not be determined if an inconsistency in documentation between the resident's electronic medication administration record (eMAR) and the narcotic count logbook were the result of deliberate medication diversion or a documentation error. The AP denied the allegation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed resident cares provided by staff.

The resident resided in an assisted living facility. The resident's diagnoses included coronary artery disease. The resident's services included assistance with medication administration. The resident's assessment indicated the resident required minimal assistance with activities of daily living.

The facility's internal investigation indicated the resident reported she had a problem getting her hydrocodone the day before, although she believed she had gotten some in the afternoon. A nurse reviewed video footage and observed the AP opening the narcotic medication box and removing medication. The AP then entered the resident's room. After exiting the resident's room, video footage revealed the AP grabbing something out of his pocket and putting it into his mouth. The nurse reviewed the narcotic logbook and saw the AP had signed out two tablets of hydrocodone for the resident. The nurse reviewed documentation in the resident's eMAR and there was no correlating documentation of the hydrocodone being administered to the resident. The AP's employment was terminated.

The resident's eMAR indicated she had an order for hydrocodone 5/325mg, 1-2 tablets every four hours as needed (PRN). On the date in question, the eMAR indicated the resident received a total of six tablets of hydrocodone, none of which were signed out by the AP. The resident's individual narcotic record in the narcotic logbook, which recorded the hydrocodone tablet count, correlated with the three administration times documented in the eMAR, signed out and administered by other staff members. That evening, the AP signed out two tablets of the resident's hydrocodone from the narcotic logbook. However, the two tablets of hydrocodone were not documented in the resident's eMAR. The AP did, however, document administering the resident's scheduled medications in the eMAR that evening.

The AP's training files indicated he received both classroom and observed competency trainings in medication administration and documentation. A corrective action indicated the AP was terminated due to medication concerns. The corrective action indicated the AP signed out the resident's hydrocodone in the narcotic log, but did not document it in the resident's eMAR. The resident said she did not receive her hydrocodone at that time. The AP left medication cart drawers open after he walked away, and he touched medications with hands. The AP also placed medications outside a room on a handrail while going into another room, and he placed medications in his pockets. After the medication pass, staff observed the AP via video footage sit in a recliner and appear to fall asleep. The corrective action did not mention the AP ingesting any resident's medication.

The police department said no report was on file for this incident.

When interviewed, a nurse said the resident reported she did not get her pain medication for a significant amount of time the day before. The nurse found a discrepancy in documentation between the narcotic logbook and the resident's eMAR. The AP documented signing out two tablets of hydrocodone in the narcotic logbook but did not document administering the medication in the resident's eMAR. The nurse reviewed video footage and said there was a period when the AP moved back and forth, looking at people, looking around, going back and forth from the medication cart to the desk. Then the AP turned around and the nurse said she saw him take medication out and enter the resident's room. After leaving the resident's room, the nurse said she saw the AP take medication out of his pocket and put it into his mouth. After that, the AP sat in a recliner and appeared to go to sleep.

When interviewed, an administrator said she, too, reviewed video footage of the AP's medication pass. The AP had a cup of pills in his pocket, went into the resident's room, and came back out. The administrator said she did not see the AP ingest medication on the video.

When interviewed, the AP denied taking or ingesting the resident's pain medication. The AP said it took staff three days to tell him his employment was being terminated, and there was no mention of him taking the resident's medication in the termination notice. The AP believed his termination was retaliation for a complaint he had filed.

When interviewed, the resident did not recall one specific date in which she did not receive hydrocodone, as she said there were several times she did not receive her pain medication when she requested it. The resident said she had many conversations with the nurse about not getting her pain medication as requested, but the issue had since improved.

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: Yes.

Family/Responsible Party interviewed: No, the resident is her own guardian.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:

No further action taken at this time.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38983	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/25/2025
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NAME OF PROVIDER OR SUPPLIER PERSONAL CARE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 3850 JEFFERSON STREET NE FRIDLEY, MN 55432
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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>Initial Comments</p> <p>On June 25, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL389834568C/#HL389832602M. No correction orders are issued.</p>	0 000	<p>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 _____