Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL394856281M
Compliance #: HL394859340C

Date Concluded: March 31, 2025

Name, Address, and County of Licensee Investigated:
Harmony Gardens
1440 County Road C East
Maplewood, MN 55109
Ramsey County

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

Evaluator's Name: Lissa Lin, RN
Special Investigator
Rhylee Gilb, RN
Special Investigator

Finding: Substantiated, individual responsibility

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 perpetrators (AP 1 and AP 2) financially exploited residents when they stole the residents' controlled medications.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated for residents 1, 2, 3, 5, 6, 7, 8, 9, 11, 13, 14, 16, 18 and 21. AP 1 and AP 2 were responsible for the maltreatment. AP 1 and AP 2 were nurses and AP 1 supervised AP 2. AP 1 and AP 2's drug diversion included documentation inconsistencies with pharmacy deliveries; inconsistencies or a lack of documentation in the narcotic records regarding scheduled and as needed (prn) narcotic medication counts, new, refilled or discontinued narcotic prescriptions, and legibility of entries. There were documentation inconsistencies in the electronic medication administration record (MAR). AP 1 and AP 2 failed to follow medication destruction policies and procedures.

The Minnesota Department of Health determined financial exploitation was inconclusive for Residents 4, 10, 12, 19, and 20.

The Minnesota Department of Health determined financial exploitation was not substantiated for resident 15 and resident 17.

The investigators conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigators contacted law enforcement, the Drug Enforcement Administration officer and the pharmacist. The investigation included review of the resident records, pharmacy records, facility internal investigation, facility narcotic records, personnel files, staff schedules, law enforcement report, facility security video footage and pictures, and related facility policy and procedures. Also, the investigators observed medication storage and controlled substance storage in the units and nursing office.

The residents resided in an assisted living facility, and all received medication administration services.

During an interview, management staff stated they received suspicion and reports of suspected of drug diversion occurring. The initiated a facility internal investigation and began reviewing resident narcotic records, pharmacy delivery records, resident medication administration records (MAR) and security video. As patterns of diversion were evident of AP 1, management staff stated they then continued their investigation going further back of dated records for review. Management staff stated they removed AP 1 and reported drug diversion to law enforcement. Management staff stated AP 1 managed the nursing department and during her employment, she had a medication cart in the nurse's office, maintained a master nurse's narcotic book and kept resident narcotic medication in that cart. In addition, each unit had a narcotic book for each medication cart. The nurses had keys to open all narcotic boxes on the unit medication carts.

During an interview, a nurse stated AP 1 managed both her and AP 2. AP 2 was responsible for managing all of the medications for the residents and she was responsible for completing all of the resident assessments.

Investigative interviews multiple staff stated AP 1 often offered to administer noon medication pass for particular residents with narcotic medications. AP 1 would document under the ULP that had been signed in the eMAR system, impersonating the ULP administering the medication. ULP 2 stated the ULPs were under the impression AP 1, who was the director of nursing, could help and sign off medication administration for staff. When management started their internal investigation, all ULP were instructed to change their passwords. ULP 2 stated during interview, AP 1 stood at her medication cart, upset that she could not get into the computer and asked her why she was logged out of the eMAR. ULP 2 stated she told AP 1 she had changed her password and AP 1 was upset.

Review of 21 resident narcotic records compared with MARs indicated AP 1 had a diversion tendency to remove controlled medications around 10:00 a.m. (ranging from 9:00 a.m. to 11:00 a.m.), around 1:00 p.m. and around the end of the day at 4:00 p.m. or 5:00 p.m. AP 1 diversion patterns included removing controlled medications with no evidence of administering the medication, removing the controlled medication on the narcotic record with a ULP signed on the MAR (indicative of staff reporting she was signing the computer while recorded in with their user log in). No other staff had a pattern of removing a controlled medication from the narcotic record and failing to document administration in the resident MAR. ULP documented accurately administration in the MAR and signing out the controlled substance from the narcotic records, with consistent mirroring times, whereas AP 1 did not.

Resident 1

Resident 1's diagnoses included dementia, congestive heart failure, a closed fracture of her right femur and pain. She was enrolled in hospice and her prescribed medications included the narcotic oxycodone for pain. Resident 1 is deceased.

AP 2 faxed an order from hospice to the pharmacy for oxycodone 2.5 milligrams (mg) tablets by mouth every four hours as needed (PRN) for pain.

The narcotic record showed AP 1 received and recorded 60 oxycodone 2.5 mg tablets and then removed one 2.5 mg tablet to give to resident 1, which left 59 tablets. Several days later, AP 1 took a hospice telephone order for oxycodone 5 mg tablets by mouth every morning and night for increased pain, and every 2 hours PRN for increased pain.

The pharmacy delivery records indicated 30 oxycodone 5 mg tablets were delivered to the facility. A nurse signed for them. The new oxycodone 5 mg prescription was added to the same unit narcotic record page as the oxycodone 2.5mg count, but the count did not reflect the additional 30 tablets.

AP 1 documented in the individual narcotic record that she removed and signed for a oxycodone 2.5 mg tablet but did not sign resident 1's MAR that she gave the medication.

The next day, AP 1 removed and signed for a 5mg tablet in the morning and again four hours later. The MAR indicated only one dose of oxycodone was given that day and another staff member signed for it, not AP 1. There were still 24 oxycodone tablets recorded at the bottom of the unit narcotic record page and the page was crossed out. There was no medication disposition form.

Another page in the unit narcotic record, indicated 20 oxycodone 5 mg tablets were received (no date, no signature) and "new order 5 mg not 2.5 mg" was written across the top of the page. The pharmacy delivered 30 tablets, not 20. There was no activity on the record page or

documentation on what happened to the 20 oxycodone tablets. There was no medication disposition record.

AP 1 diverted one dose of oxycodone.

Resident 1's power of attorney (POA) said she was not aware of the drug diversion.

Resident 2

Resident 2's diagnoses included Crohn's disease and severe protein-calorie malnutrition. She was enrolled in hospice. Resident 2 is deceased.

There were over 20 entries recorded in the master narcotic record for resident 2's morphine and lorazepam prescriptions over two months. Two of the morphine entries were duplicates and had inaccurate or duplicate delivery dates.

Resident 2 had a prescription for morphine 2.5 mg, give 2 tabs (5 mg) by mouth twice daily and 2 tabs (5 mg) every hour as needed for pain and shortness of breath (SOB).

Pharmacy delivery records indicated 30 morphine 2.5 mg tablets were delivered on one date. AP 2 recorded and signed in R2's individual narcotic record that she received 15 morphine 2.5 mg tablets and put them in the unit cart. The page was crossed out and had "AM PM" handwritten at the top of the page. On the following page, AP 2 recorded and signed that she received 15 morphine 2.5 mg tablets and put them in the unit cart. This was on a duplicate of the preceding "AM PM" record page, with the prescription number and date. The page was crossed out and had "PM" handwritten at the top. No doses were removed. There was no medication disposition record of the 15 tablets.

Someone recorded but did not sign in resident 2's individual narcotic record that 15 morphine 2.5mg tablets were received five days after the pharmacy delivery. "Give 2 tabs" was handwritten at the top of the page. Three days later, there was only 1 morphine 2.5 mg tablet left. There was no documentation on what happened to the one tablet and the record page was crossed out.

Pharmacy delivery records indicated 90 morphine 5 mg tablets were delivered and signed for by a staff member. AP 2 recorded and signed in resident 2's individual narcotic record that she received 15 tablets and put them in the unit cart. "PRN" was handwritten at the top of the page. AP 1 also recorded and signed one line below, "put in," followed by illegible writing.

AP 1 removed and signed for one PRN morphine tablet 30 minutes after an unlicensed personnel (ULP) signed resident 2's MAR that morphine and lorazepam were given. There was not evidence AP 1 administered the dose of morphine. AP1 diverted 1 morphine 5 mg tablet.

A few days later someone removed one morphine 5 mg tablet but did not sign for it and did not update the count. A few days later there were five tablets left, but the page was crossed off. There was no medication disposition record for the 5 morphine tablets.

AP 2 documented and signed in resident 2's individual narcotic record that she received 15 morphine 5 mg tablets. The morphine tablets were part of the same prescription number as the tablets delivered four days earlier. Another staff member removed and signed for 2 tablets, which left the count at 13. The record page was crossed out. There was no medication disposition record for the 13 morphine tablets.

A staff member recorded 15 morphine 5 mg tablets were received but did not sign resident 2s individual narcotic record. The narcotic record showed the same prescription number as the 90 total delivered. The record had a count of 1 tablet, not 15. Two days later a staff member removed and signed for the 1 tablet. There were 45 missing morphine 5 mg tablets from the same prescription number for resident 2.

AP 2 documented and signed resident 2's individual narcotic record that she received and put 30 morphine 5mg tablets, designated as PRN into the unit cart. Staff members documented and signed for removed doses and the count was maintained until about two weeks later when someone removed one tablet without documenting a date, time, dose, route and signature. There were two remaining tablets recorded at the end of page. Someone documented the two remaining tablets were continued on another record page. That record page had a different morphine prescription number for morphine 5 mg tablets. That page indicated 15 tablets were received but the count showed just one remaining tablet.

Resident 2's individual narcotic record indicated AP 2 received and signed for 15 morphine 5mg tablets. Another staff member removed and signed for 2 tablets. There was no documentation on what happened to the remaining 13 tablets and the record page was crossed out.

The pharmacy delivery records indicated two prescriptions of morphine 10 mg tablets (90 tablet and 30 tablet supply) and one prescription for lorazepam tablets (28 tablets) were delivered on the same day. Another staff member signed for the pharmacy delivery.

Resident 2's individual narcotic record indicated AP 2 received and signed for 15 morphine 10 mg tablets and documented put in the unit cart. The record page was crossed off.
There was no medication disposition record for the remaining morphine tablets.

Resident 2's individual narcotic record indicated AP 2 recorded and signed that she received 14 lorazepam 0.5 mg tablets and put in the unit Cart. About 10 days later, 4 lorazepam tablets remained. There was no documentation on what happened to the 4 lorazepam tablets and the record page was crossed out.

Another record page indicated AP 2 received and signed for 28 lorazepam 0.5 mg tablets.

AP 1 removed and signed for 1 lorazepam tablet and the count was 27. Staff removed three more tablets over two days. AP 1 removed and signed for 1 tablet and there were 24 tablets left. The page was crossed off. There was no medication disposition record for the 24 remaining tablets.

AP 1 diverted 1 lorazepam tablets.

Resident 2's POA said he was not informed of any drug diversion.

Resident 3

Resident 3's diagnoses included chronic hypertensive chronic kidney disease, pa[illegible] age-related cognitive decline.

Resident 3 had a prescription for acetaminophen-codeine (APAP/co[illegible]ne) 300-30 mg (brand name Tylenol #3), 120 tablets, give 2 tabs orally twice a day. Addi[illegible]ally, therapy was ordered for evaluation and treatment for spinal stenosis and right shoulder pain. The prescription was for 30 days. AP2 faxed the prescription to the pharmacy.

Pharmacy delivery records indicated AP 1 signed for the medication delivery which included 28 APAP/codeine tablets for resident 3.

Resident 3's individual narcotic record indicated AP 1 received and signed for 14 APAP/codeine tablets and "PM" was handwritten at the top of the record page. AP 1 removed and signed for 2 tablets in the afternoon, even though the medication was scheduled for the evening. There was not evidence AP 1 administered the tablets to resident 3.

Three days later, an unknown person documented "took out of cart," removed the 10 remaining APAP/codeine tablets and indicated zero tablets were left. AP 1 documented resident 3's medications were on hold.

Another record page had "AM" handwritten at the top and indicated 14 APAP/codeine tablets were received. Two days later, AP 2 documented "took out of cart" and documented zero tablets left.

Resident 3's progress notes indicated AP 1 documented resident 3 had confusion and shoulder pain but could not rate her pain. She was sent to emergency room and hospitalized for about one week before she was transferred to a transitional care unit (TCU). AP 1 documented on resident 3's MAR she was hospitalized and the APAP/codeine was on hold the same date AP 1 and AP 2 removed the remaining 20 tablets. There was no provider order to discontinue the APAP/codeine.

A medication disposition record for resident 3 indicated AP 1 disposed of 8 “Tylenol #3” tablets and did so without the required second staff person to witness and initial.

AP 1 diverted 14 APAP/codeine tablets. AP 2 diverted 10 APAP/codeine tablets.

Resident 3’s family member said she was not notified about the drug diversion.

Resident 5

Resident 5’s diagnoses included type 2 diabetes with chronic kidney disease, aphasia, unspecified pain. Resident 5 is deceased.

Resident 5 had a prescribed order for tramadol 50 mg tablets, take 1 tablet by mouth twice daily. Resident 5’s MAR instructed staff to record in narcotic book and confirm the count for the tramadol 50 mg tablets.

Pharmacy delivery records indicated resident 5 had a delivery of 90 tramadol 50 mg tablets. A staff member signed for the delivery.

Resident 5’s individual narcotic record indicated a staff person received and signed for 60 tramadol 5 mg tablets even though the pharmacy delivered 90 tablets.

A staff member removed and signed for 1 tablet. The following day another staff member removed and signed for 1 tablet. Later that day, the remaining 29 tablets were transferred to a new page although the page had more entry lines available. The next record page indicated 29 tramadol tablets as transferred, and AP 1 removed and signed for one tramadol tablet. On resident 5’s MAR, another staff member initialed that she gave the tramadol, not AP 1. The a.m. and p.m. doses were recorded together on the same record page. The count was maintained until there were zero tablets.

Pharmacy delivery records indicated 90 tramadol 50 mg tablets were delivered yet the individual record page count did not reflect the second delivery of 90 tramadol.
Resident 5’s individual narcotic record indicated AP 2 received and signed for only recorded 29 tramadol 50 mg tablets. The a.m. and p.m. doses were recorded together on the same record page and was maintained until there were no tablets. There were scribbles in the “Date of Discontinuance” and “Amount Remaining” sections at the bottom of the record page.

Pharmacy delivery records indicated resident 5 received a third delivery of 90 tramadol 50mg tablets. AP 2 received and signed for 30 tramadol 50 mg tablets in the individual narcotic record and documented put in the unit cart, “PRN” was written at top of page. One week later, AP 1 and another nurse documented the remaining 26 tablets were “transferred to nurse’s med cart. ” At the bottom of the record page, a discontinuance date was recorded, “amount remaining 26” and “quantity transferred 26.” There was no other narcotic page with the 26 tablets. There was no documentation on what happened to the remaining 64 tramadol tablets.

Resident 5 had a prescription to start tramadol 100 mg tablet by mouth every morning, and 50 mg every evening and 50 mg PRN daily. The previous order of tramadol 50 mg twice daily was discontinued.

An individual narcotic record page indicated AP 2 received and signed for 30 tramadol 100 mg tablets and documented “new order put in cart.” “AM” was handwritten at top of page. Three days later AP 1 and another nurse removed the remaining 24 tramadol tablets and “transferred to nurse’s med cart.”

An individual narcotic record page indicated AP 2 received and signed for 30 tramadol 50 mg tablets. “PM” was written at the top of page. Three days later AP 1 and another nurse removed and signed for the remaining 26 tablets and documented “transferred to nurse’s medcart.” There were no medication disposition records for the tramadol 50 mg.

AP 1 diverted 3 tramadol tablets.

Resident 5 had a prescription to start oxycodone 5 mg twice daily and stop all tramadol orders. The MAR instructed staff to record count in narcotic book.

Pharmacy delivery records indicated delivery of 60 oxycodone 5 mg tablets. AP 1 signed for the delivery.

The individual narcotic record indicated staff received and signed for 30 tablets even though 60 were delivered. During the next few days the count was maintained. Then, AP 1 removed and signed for 22 oxycodone tablets and documented “removed from cart put in med room.” After her signature there was a written slash mark and an initial. There was no other narcotic record with the other 30 delivered oxycodone tablets.

AP1 diverted 30 oxycodone tablets.

Resident 6

Resident 6’s diagnoses included dementia and Alzheimer’s disease with late onset. She was enrolled in hospice.

Pharmacy delivery records indicated resident 6 received 30 hydromorphone 1 mg tablets and 30 lorazepam 0.5mg tablets. No staff signed the pharmacy delivery record.

Resident 6 had a hospice prescription for lorazepam 0.5 mg every four hours PRN for anxiety and agitation.

Resident 6 had duplicate lorazepam prescription transcribed on her MAR. Both had the same prescription number and start date, but staff used the first entry to document lorazepam administered.

The individual narcotic record for resident 6 indicated someone received 30 lorazepam 0.5 mg tablets. The pharmacy refill sticker placed on the upper left hand corner of record page indicated the refill happened a day later than the first handwritten record entry made by AP 1.

AP 1 removed and signed for 1 lorazepam tablet on several dates. On the first date, another staff member documented the medication was given in resident 6's MAR, not AP 1. AP 1 removed 3 tablets on different dates with no evidence of administration to resident 6. AP 1 diverted 3 tablets.

About one week later, a new individual narcotic record sheet indicated 29 lorazepam tablets were received. There was no documentation to indicate the tablets were transferred from a previous record page. There were two "22" amounts scribbled over in the "Quantity Received" section. AP 1 removed and signed for 1 tablet but documented the date, then drew a line through the time and dose and route and documented "removed/destroyed" without a second witness. Several days later, AP 1 signed and removed 1 tablet, drew a line through the time and dose sections, and documented "removed" without a second witness. AP 1 diverted 2 tablets.

Resident 6 had a prescription for hydromorphone 1 mg tablet every three hours PRN for pain, and shortness of breath.

The individual narcotic record indicated someone documented 30 tablets were received. About three weeks later, AP 1 removed and signed for 1 hydromorphone tablet, which another staff member documented on the MAR as given. The remaining tablet count was 29 and there was no further documentation on the narcotic record page other than AP 1's. There was no medication disposition record for the 29 hydromorphone tablets.

During an interview, a nurse said AP 1 regularly went to the memory care unit to pass narcotic medications for only a few residents. The nurse said it was always the same two or three residents, including resident 6.

Resident 6's family member said she was not notified of any drug diversion.

Resident 7

Resident 7's diagnoses included wedge compression fracture of 5th lumbar vertebrae, agranulocytosis secondary to cancer chemotherapy and age-related osteoporosis.

Resident 7 discharged from a transitional care unit (TCU) to the facility assisted living section. She was discharged with her current medication per protocol. She discharged with medications

that included hydrocodone-acetaminophen (APAP) 5-325mg tablets, every six hours PRN for unspecified osteoarthritis.

Resident 7's individual narcotic record indicated AP 1 received and signed for 19 hydrocodone/APAP tablets and documented "put in cart" and recorded the amount remaining as 18 tablets. AP1 did not sign the dose, time and route for 1 tablet on the narcotic record sheet and there was no documentation in the MAR that AP 1 or any other staff gave resident 7 the hydrocodone. AP1 diverted 1 tablet.

Resident 7's individual narcotic record indicated two days later a staff member removed and signed for one tablet. The med pass detail report showed the staff person signed for the tablet as given. Around midday, AP 1 removed and signed for one hydrocodone/APAP tablet. The medication passing detail and MAR did not show AP 1 or any other staff gave a second hydrocodone/APAP tablet to resident 7 that day. AP1 diverted 1 tablet.

Several days later resident 7's individual narcotic record indicated AP 1 removed and signed for 1 tablet but no evidence it was administered to resident 7. Another staff member removed and signed for 1 tablet and documented it as given in the MAR. AP 1 diverted 1 tablet.

Another individual narcotic record page indicated staff received 30 hydrocodone/APAP 5-325mg tablets. Staff members removed and signed for 1 tablet and maintained the count until there were 16 tablets left. AP 1 documented "[illegible]…for D/C" and signed her name. There was no disposition record for the tablets. AP1 diverted 16 tablets.

Another individual narcotic record page indicated 30 tablets were received. AP 1 removed and signed for 1 tablet, but on the line below, wrote the same date, time and route as she did on the line above, then drew a line through the entry, wrote "error" and changed the count from 25 tablets to 24, even though her documentation indicated the second entry was an error and should not have changed the count. AP 1 diverted 1 tablet.

Resident 7's family member said he was not made aware of any drug diversion.

Resident 8

Resident 8's diagnoses included transient ischemic attack, dementia and spinal stenosis.

Resident 8 had a prescription for hydromorphone 120 tablets, 30-day supply, take 1 tablet every six hours scheduled and every one hour PRN for pain or shortness of breath.

Pharmacy delivery records indicated resident 8 received the first of two deliveries of 120 hydromorphone 1 mg tablets. AP 2 signed for the first pharmacy delivery.

In resident 8's individual narcotic record, AP 2 signed that she received 60 tablets and placed in the unit cart. AP 2 failed to log in the remaining 60 tablets and no other record with the supply. AP 2 diverted 60 tablets.

Resident 8's individual narcotic record indicated AP 1 removed and signed for 2 tablets about two hours apart on the same day. The first tablet was signed for on the MAR by another staff member. The second tablet was not documented on resident 8's MAR as given by AP 1 or any other staff member. AP 1 diverted 1 hydromorphone tablet.

A few days later, AP 1 removed and signed for 1 tablet on the individual narcotic record but there was no documentation on resident 8's MAR that AP 1 or any other staff gave the hydromorphone tablet at that time. AP 1 diverted 1 tablet.

A few days later, AP 1 removed and signed for 1 tablet on the individual record page, but did not indicate a.m. or p.m. with the time she entered. There was no documentation on resident 8's MAR that AP 1 or any other staff administered that dose. AP 1 diverted 1 tab.

About three weeks later, pharmacy delivery records indicated resident 8 received the second pharmacy delivery of 120 hydromorphone tablets and AP 2 signed the pharmacy delivery slip. The prescription was a reorder for hydromorphone 1mg tablets. The narcotic record page indicated only 60 tablets were in recorded by a staff member. AP 2 diverted 60 hydromorphone tablets.

Internal investigation records indicated management verified with the pharmacy that on the second delivery, 120 hydromorphone tablets were delivered, 5 cards were sent with 24 tablets per card (four card for scheduled administration times and one card for PRN.)

Resident 's family member did not respond to a phone call.

Resident 9

Resident 9's diagnoses included chronic diastolic heart failure, kidney disease, and monoplegia after a stroke. Resident 9 was enrolled in hospice.

Resident 9 had a prescription for lorazepam 0.5mg, 1 tablet every four hours PRN for anxiety/agitation.

Pharmacy delivery records indicated resident 9 received a delivery of 15 lorazepam 0.5 mg tablets and AP 2 signed for them.

Resident 9's individual narcotic record indicated 10 tablets were received, even though 15 were delivered and signed for by AP 2. There were also 2 tablets left on the narcotic record sheet and the page was crossed off. There was no disposition form for the 2 lorazepam tablets under the prescription number. AP 2 diverted 5 tablets.

AP 1 and AP 2 removed and signed for 1 tablet in the narcotic record for the scheduled morning dose. There was no documentation in resident 9's MAR that AP 1 or AP 2 gave him the lorazepam tablet. It was inconclusive who, AP 1 or AP 2, diverted the tablet.

AP 1 removed and signed for 1 tablet three hours later. There was no documentation in the MAR that AP 1 gave resident 9 the tablet. AP 1 diverted 1 tablet.

Pharmacy delivery records a month later indicated resident 9 received a second lorazepam delivery of 24 tablets. A staff member signed for the delivery.

A few days later a third pharmacy delivery of 24 lorazepam tablets arrived. Someone initialed "AM" on the slip by the medication name. There were no record entries on new record pages for the two lorazepam deliveries.

AP 1 completed a medication disposition form that she destroyed 14 and 11 lorazepam tablets (35 total). The prescription numbers were for 2 different lorazepam prescriptions. There was no second staff witness signatures.

Resident 9 had a prescription for oxycodone 2.5 mg tablet, 1 tablet every hour PRN for pain/SOB, continue oxycodone 2.5 mg twice daily scheduled as ordered.

Pharmacy delivery records indicated 30 oxycodone 5 mg tablets were delivered and AP 2 signed for the delivery. Pharmacy delivery records indicated 60 oxycodone 2.5 mg tablets were delivered and AP 2 signed the delivery.

Resident 9's individual narcotic record indicated he had a prescription for oxycodone 2.5mg, 1 tablet four times daily scheduled for pain and SOB.

Handwritten at the top of the narcotic record page was administration times for 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m., and direction "2 TABS." The pharmacy sticker indicated 15/60 tablets delivered. The record page indicated 15 oxycodone tablets were received and entered onto the record page by AP 2. The count reflected only one tablet given for the first few days by various staff members, but then reflected 2 tablet doses were given. The count was maintained until there were zero tablets left.

Another record page with the same prescription number indicated AP 2 received and signed for 15 oxycodone 2.5 mg tablets. Handwritten at the top of the page "EVERY 4 HOURS 2 TABS." There were 2 tablets left two days later and an unknown staff member wrote "Transferred to nurse's med cart." Another nurse documented the remaining two tablets were transferred and the page was crossed off.

There was no record of the other 30 oxycodone tablets delivered as part of the total 60 delivered. AP 2 diverted 30 tablets.

Pharmacy delivery records indicated two prescriptions for morphine 5 mg (supply of 24 tablets) and oxycodone 5 mg (supply of 20 tablets) were delivered. AP2 signed for the delivery.
A narcotic record page indicated 24 morphine 5mg tablets were received. When there were 13 tablets left, AP 1 documented “removed- DC Med.” Resident 9’s records indicated the resident 9 had died. There was no medication disposition form. AP 1 diverted 13 morphine.

A narcotic record page for resident 9 indicated 20 oxycodone 5 mg tablets (different prescription number than delivered) were received. When there were 13 tablets left, AP 1 documented “removed- DC Med.” There was no medication disposition form. AP 1 diverted 13 oxycodone tablets.

An individual narcotic record page for resident 9 indicated AP 2 received 30 tablets and documented put in the unit cart. The count was maintained until there were 5 tablets left. The page was crossed off and there was no documentation the medication was moved.

An individual narcotic record for resident 9, with the same prescription number indicated 60 oxycodone 2.5 mg tablets were received by AP 1 and AP 2. AP 1 and AP 2 documented put in the unit cart and then documented “destroyed,” with the total tablets as zero.

AP 1 completed a disposition form that she destroyed 15 oxycodone tablets but there was no second staff witness and signature.

Resident 9‘s family member said she was not made aware of the drug diversion.

Resident 11
Resident 11’s diagnoses included osteomyelitis (bone infection) and type 2 diabetes. Resident 11’s progress note, written by AP 1, indicated after a return from a transitional care unit, resident 11 started services for medication administration and management due to a history of incorrectly taking medications and forgetfulness. Resident 11’s physician orders included oxycodone 5 mg, take 1 to 2 tablets every four hours as needed (PRN).

Resident 11’s MAR had incorrectly transcribed resident 11’s oxycodone order and it was transcribed to as oxycodone 5 mg, administer twice daily scheduled at 8:00 a.m. and 8:00 p.m. Pharmacy delivery records indicated she had a delivery of 60 oxycodone 5 mg tablets the same date as readmission from a hospitalization. AP 2 signed the pharmacy delivery receipt accepting the delivery. AP 2 logged the received oxycodone into the master narcotic logbook, but wrote 29 tablets were received, not 60 as delivered. The same day, AP 1 and AP 2 signed an entry indicating 29 tablets were “received/removed.” AP 1 nor AP 2 recorded the 60 tablets of oxycodone into any other narcotic logbook. Although there was no narcotic record to monitor the count of oxycodone, Resident 11’s MAR indicated she received 20 tablets with medication

administration by ULP. After 10 days since her return, leave records indicated resident 11 was hospitalized again for approximately six weeks. It was inconclusive who took the missing 40 tablets.

Upon her second readmission, resident 11 had no changes to her service plan and continued to received medication administration. Although resident 11's previous oxycodone order was transcribed incorrectly, ULP were responsible to administer it. However, upon her return to the facility, resident 11's oxycodone remained transcribed incorrectly with scheduled twice daily administrations when there was no physician order change from PRN and the direction was changed to "self-administer" on the MAR instead of ULP administering. The correct PRN oxycodone order was transcribed to resident 11's MAR for ULP to administer the PRN doses as ordered. The inappropriate medication set up was then controlled by the nurses (AP 1 and AP 2) to manage supplying oxycodone to pill caddy without a physician's order.

During an interview, AP 2 stated AP 1 directed to start medication set up using a twice a day, seven day pill box. AP 2 stated it was unusual because the facility leadership did not allow use of pill caddy medication set up, but AP 1 made an exception. Resident 11 began to report she was missing oxycodone from her medication pill set up from the evening spot. AP 2 stated AP 1 then had a second pill caddy for just her oxycodone to be set up, twice a day (morning and night), stating to AP 2 if resident 11 takes too much oxycodone, they can monitor her for it. AP 1 began to go to the unit where resident 11 lived, that had no cameras, every day to check on resident 11. AP 2 stated AP 1 also began doing the medication set up for resident 11, which was odd because that was her job duty, not AP 1's.

Pharmacy delivery records indicated resident 11 had a second oxycodone 5 mg supply delivery of 56 tablets. AP 2 signed the pharmacy delivery receipt accepting the delivery. AP 2 never logged receipt of the 56 tablets into any narcotic record. Review of resident MARs and other narcotic records indicated resident 11's medication administrations were accounted for with other prescriptions and this pharmacy prescription was not accounted for in any documentation. Therefore, AP 2 diverted 56 tablets of oxycodone 5mg.

Pharmacy delivery records indicated resident 11's had a third oxycodone 5 mg supply delivery of 60 tablets. AP 2 signed the pharmacy delivery receipt accepting the delivery. AP 2 did not log any of the received supply into the master narcotic book, however documented in the unit narcotic book receipt of 40 tablets, not 60 when pharmacy pill cards have 30 doses. Additionally, AP 2 removed 16 total tablets for a medication set up of twice daily medication administration. A pill caddy had capacity for one week's supply, so only 14 tablets. AP 2 diverted 22 tablets of oxycodone 5 mg.

Pharmacy delivery records indicated resident 11 had a fourth oxycodone 5 mg delivery of 60 tablets, however the signature of delivery receipt was not found in the records. MAR and narcotic records indicated 24 tablets were not logged into the narcotic record upon delivery and unknown who logged in the amount. PRN administrations were accounted for. AP 1 removed

one tablet with no evidence of administration at 9:30 a.m. AP 2 documented removing 14 tablets for medication set up at 12:00 p.m. Two hours later, AP 1 documented removing one tablet of medication set up, when it was already completed by AP 2. AP 1 diverted 2 tablets of oxycodone 5 mg.

Pharmacy delivery records indicated resident 11 had a fifth oxycodone 5 mg delivery of 90 tablets, however there was no signature at the bottom of the delivery receipt. There was no master narcotic record with this delivery supply, but AP 2 documented on two unit narcotic record pages transferring 13 tablets to the unit cart on one page and 55 tablets on another page. The narcotic record accounted for PRN administrations and medication set up, with 38 tablets remaining. AP 1 and AP 2 both signed together they removed 38 tablets for "move to the nurse cart" but no supply was logged into the master narcotic book. The facility internal investigation indicated the 38 tablets were unaccounted for. It was inconclusive who, between AP 1 and AP 2, diverted 38 tablets of oxycodone and 22 diverted by an unknown AP of the delivery of the oxycodone supply.

Resident 11's physician orders included a PRN order for acetaminophen with codeine (an opioid combination with a pain reliever). Resident 11's MAR and narcotic records indicated she had no administrations of the medication, and the physician discontinued the order. Pharmacy delivery records indicated resident 11 had an acetaminophen with codeine supply of 10 tablets delivered. Although, the signature of delivery receipt was not found in the records, AP 1 signed logging in 8 tablets of the supply into the unit narcotic record, not 10 as delivered. AP 1 documented the next day she removed 2 tablets for medication set up, although resident 11 did not have scheduled acetaminophen with codeine ordered nor transcribed onto her MAR. The same date, AP 1 documented she moved 6 tablets "due to orders." There was no disposition record of medication destruction and the orders were not discontinued by the physician the day after the pharmacy delivery. AP 1 diverted 10 tablets of acetaminophen with codeine.

During an interview, AP 2 stated the facility did not allow medication set up with pill caddies, but AP 1 made an exception for

During an interview, ULP 2 stated she understood resident 11 was independent and ULP were required to monitor every morning resident 11 took her medications from her pill caddy. ULP 2 stated usually she worked day shift, but one day she worked in the evening. Resident 11 came to her to report her evening oxycodone had been missing for a whole week. Resident 11 stated she had been watching her pill set up for two weeks and noticed her evening oxycodone had been missing. ULP 2 told resident 11 she would report to the nurses and advised resident 11 to set up a camera. ULP 2 stated AP 1 came her to her upset she gave a resident the idea to set up a camera. After that incident, AP 1 never scheduled ULP 2 to work the unit resident 11 was on again.

The investigator attempted to interview resident 11 while onsite, however resident 11 was not available in her apartment.

Resident 13
Resident 13's diagnoses included Lewy Body dementia. Resident 13's medication orders included orders for lorazepam (anti-anxiety) 0.5 mg as needed and hydromorphone (narcotic pain medication) 1 mg as needed.

Pharmacy delivery records indicated resident 13 had a lorazepam 0.5 mg supply delivery of 15 tablets. Resident 13's MAR and narcotic records indicated 6 tablets had matching administration documentation. AP 2 removed 9 remaining tablets, but only logged 5 tablets into a new narcotic record page. AP 1 signed she removed 1 tablet with no record of administration. The same day AP 1 and AP 2 signed together they removed another tablet with no record of administration. Five days later, again both AP 1 and AP 2 signed together they removed 1 tablet with no record of administration and had 2 tablets of supply remaining. However, the facility internal investigation did not locate the 2 remaining tablets. AP 2 diverted 4 tablets of lorazepam 0.5 mg. AP 1 diverted 1 tablet of lorazepam 0.5 mg. It was inconclusive who, between AP 1 and AP 2, diverted the other 4 tablets of lorazepam.

Pharmacy delivery records indicated resident 13 had a second lorazepam 0.5 mg supply delivery of 14 tablets. The lorazepam was logged into the master narcotic page; however, the handwritten date was written as received two weeks after the accurate date of delivery from the pharmacy. There were no administrations documented on the MAR and narcotic record from ULP. The MAR and the memory care narcotic records indicated administrations were from the third lorazepam delivery supply. Medication orders indicated resident 13's lorazepam order was discontinued, and six weeks later AP 1 and AP 2 documented on the master narcotic page they removed one tablet on three separate days. Both AP 1 and AP 2 signed the remaining amount left and last to handle the medication. The narcotic page had a slash through the page with no indication of disposition. There was no medication disposition record for this prescription. It was inconclusive who, between AP 1 and AP 2, diverted all 14 tablets.

Pharmacy delivery records indicated resident 13 had a third lorazepam 0.5 mg supply delivery of 30 tablets. Resident 13's MAR and narcotic records indicated 16 tablets had matching administration documentation. AP 1 documented she removed 14 tablets due to discontinuation of the medication order. AP 1 did not have a second nurse sign for removal, nor was there a medication disposition records of two nurses destroying the remaining tablets. AP 1 diverted 14 tablets of lorazepam.

Pharmacy delivery records indicated resident 13 had a hydromorphone 2 mg tablet supply delivery of 15 tablets, scored in half for the 1 mg dose. Resident 13's MAR and narcotic records indicated AP 1 removed 3 tablets (6 total ½ tablet doses) with no administration documented to resident 13.

Pharmacy delivery records indicated resident 13 had a second hydromorphone 2 mg tablet supply delivery of 30 tablets, scored in half for the 1 mg dose. Resident 13's MAR and narcotic

records indicated AP 1 removed 1.5 tablets (3 total ½ tablet doses) with no administration documented to resident 13. One particular removal, AP 1 documented she removed the hydromorphone at 11:00 a.m., however the line entry below hers for the same date was an ULP removing a hydromorphone dose at 9:47 a.m. and the MAR documented administration by the ULP at 9:45 a.m.

Resident 14

Resident 14's diagnoses included history of burst vertebra fractures and resident 14 received hospice services. Resident 14's medication orders included orders for hydromorphone (narcotic pain medication), oxycodone (anti-anxiety) 0.5 mg PRN and hydromorphone (narcotic pain medication) 1 mg as needed.

Pharmacy delivery records indicated resident 14 had a hydromorphone 2 mg supply of 27 tablets delivered. Resident 14's MAR and narcotic records indicated AP 1 removed tablets with no administration to resident 14 and an extra tablet removed with her third removal.

Pharmacy delivery records indicated resident 14 had a second delivery of hydromorphone 2 mg supply of 30 tablets and a third delivery supply of 45 tablets. AP 2 signed receipt of the third delivery supply. AP 2 documented 10 tablets received on two different narcotic pages, when a card of hydromorphone is a supply of 30. AP 2 failed to log into the narcotic record the remaining 25 tablets she received from the pharmacy. Resident 14's physician orders discontinued hydromorphone, when oxycodone was ordered. AP 1 removed the remaining supply for hydrocodone, a total of 47 tablets but no medication disposition records including hydrocodone.

Resident 14's physician order lorazepam 0.5 mg and morphine 5 mg when she admitted to hospice. Pharmacy delivery records indicated resident 14 had a delivery of lorazepam and morphine supply of 15 tablets each. AP 1 and AP 2 both signed the narcotic record logging the 15 tablet supply of morphine. The page had a slash through it and the morphine supply was unaccounted for. Resident 14's MARs indicated she had no administrations of lorazepam until three months later, with one dose administered, documented accurately by a ULP. The next month's MAR had no administrations of lorazepam, however AP 1 documented she removed 1 tablet. The following month, resident 14's narcotic record indicated only AP 1 and AP 2 removed lorazepam tablets, both not indicating either the date or time of removal with no evidence of administration to resident 14. AP 1 removed tablets around 11:00 a.m. AP 1 diverted 4 total tablets of lorazepam and AP 2 diverted 1 tablet.

Pharmacy delivery records indicated resident 14 had several deliveries of oxycodone 5 mg over five months, a total of 807 tablets received. Review of resident 14's MARs, narcotic records and medication disposition records indicated AP 1 and AP 2 diverted resident 14's oxycodone. A few narcotic record pages had 1 tablet unaccounted for at the start of the medication count, however no signature was on the record to indicated which nurse logged in the medication. Both AP 1 and AP 2 documented removal of an oxycodone tablet at the time when a ULP

already administered a schedule dose and documented themselves or removing a tablet without evidence of administration to resident 14. AP 2 diverted 3 total oxycodone 5mg tablets. AP 1 diverted 146 total oxycodone 5mg tablets.

During an interview, ULP 2 stated resident 14 would be fine in the morning (regarding pain) and then around 11:00 a.m., she would administer her noon medications. AP 1 would often administer a PRN oxycodone between 8:00 a.m. and 10:00 a.m., however ULP 2 stated when she went into to administer her noon medications, earlier at 11:00 a.m., resident 14 had pain. ULP 2 stated she tried to follow AP 1 when she would administer a PRN to resident 14, but AP 1 would direct her to do something else instead.

Resident 16

Resident 16's diagnoses included dementia. Resident 16's orders included orders for oxycodone 5 mg scheduled every morning, 2.5 mg at bedtime. Resident 16 had a short-term physician order for oxycodone PRN for three days at the request of AP1 and to update the provider with effectiveness. The facility did not provide any further physician orders. Resident 16's MAR indicated there was no change to resident 16's oxycodone orders after the 3 day PRN order discontinued. Review of the next months MAR indicated resident 16 continued with the same oxycodone order, 5 mg every morning, 2.5 mg at bedtime for approximately six weeks and another 3 day PRN order for oxycodone 2.5 mg was transcribed, but then resumed the same orders again once completed. The second day into the third month, the MAR indicated resident 16's oxycodone bedtime dose increased, and the oxycodone order changed to oxycodone 5 mg twice daily.

Resident 16's narcotic records indicated AP1 removed five 2.5 mg doses of oxycodone from the narcotic record after the PRN orders were finished and no longer active. Additionally, when resident 16's oxycodone order changed to increase the dose from 2.5 mg to 5 mg, the oxycodone card of 2.5 mg doses (half 5 mg tablets), had 19 doses removed by AP 1 for destruction. Resident 16's record lacked a medication destruction record for the 19 half tablets of oxycodone, although AP 1 completed a medication destruction record for a different prescription of oxycodone with 2.5 mg doses. The narcotic record indicated on one date, AP 1 signed she removed the last dose at 8:00 a.m. A new narcotic page was started and AP 1 signed she removed the 8:00 a.m. dose for the same date, diverting one tablet and one tablet for resident 16's scheduled morning oxycodone.

During interview, AP 2 stated resident 16 was someone AP 1 often would offer to pass medications for. Towards the last couple of months [of diversion], AP 1 began to call resident 16's doctor to report resident 16 was in more pain and ask for orders to increase her oxycodone when it was not evident resident 16 was in more pain. AP 2 state it was odd because calling doctors regarding medication orders was her job, not AP 1's. AP 2 stated resident 16's spouse was also a resident who lived at the facility in an independent unit that did not have cameras and also the same unit resident 11 lived on. AP 2 stated resident 16's spouse did not have medication services, but AP 1 began to go visit him every day and he also had oxycodone for

medications. Then it got to the point AP 1 would go visit him multiple times a day. After the investigation and AP 1 was no longer employed at the facility, AP 2 stated resident 16's spouse told her he hoped AP 1 got the help she needed.

During an interview, ULP 1 stated staff were not supposed to take a pill out of the medication card and allow someone else to administer it. AP 1 began to help in the memory care unit to pass medication, at first ULP 1 did not think much of it. ULP 1 stated then she noticed AP 1 seemed to always pass medications for certain residents, including resident 14 and resident 16. She also would pass for some residents in assisted living and noticed it seemed a little earlier for the noon medication pass [than usual administration time]. ULP 1 stated she started to pass those residents AP 1 wanted to pass medications for right away so AP 1 could not administer them. She also began signing out of her computer so no one could come behind her and sign for medications with her log in.

During an interview, ULP 2 stated she never saw AP 1 actively doing it but AP 1 would approach her and say, she did resident 16's medication for her and would see AP 1 documented under her log in. ULP 2 stated resident 16 had a lot of oxycodone.

Resident 18
Resident 18 had a prescription for lorazepam, 0.5mg, 1 tablet every four hours scheduled and 0.5mg every two hours PRN for anxiety.

Resident 18 had a prescription for morphine, start 2.5mg tablet every four hours schedule for pain and shortness of breath. There was also an order to discontinue current morphine orders. AP 1 signed the order sheet.

Pharmacy delivery records indicated AP 2 signed for the delivery of 30 lorazepam 0.5 mg tablets and 15 morphine 2.5 mg tablets.

Review of internal investigation records indicated the 30 lorazepam tablets were never recorded into narcotic records for resident 18. The internal investigation records indicated the 15 morphine tablets were never recorded into any narcotic records for resident 18. AP 2 diverted 30 lorazepam tablets and 15 morphine tablets.

An undated disposition form completed and signed by AP 1, without a second witness signature, indicated AP 1 destroyed 72 lorazepam tablets and 103 morphine tablets. The prescription numbers on the disposition form did not match the prescribed medications.

Resident 21
Resident 21's diagnoses included an autoimmune disease, brain swelling and lymphoma. Resident 21's physician orders included an order for lorazepam 0.25 mg PRN. Five days later, the physician increased the lorazepam order to 0.5 mg scheduled twice daily and one tablet daily PRN. Resident 21's narcotic record indicated AP 1 documented she removed 16.5 tablets

(33 doses of 0.25 mg) for destruction almost three months after the lorazepam order changed. Resident 21's record lacked medication destruction record for the prescription AP 1 removed.

Pharmacy delivery records indicated resident 21 had a lorazepam 0.5 mg supply of 90 tablets delivered after the order changed. Resident 21's narcotic records and MARs indicated resident 21 received lorazepam as scheduled and PRN dose administrations were accounted during six weeks' time. Toward the end of the supply, resident 21's neurologist ordered to discontinue lorazepam 0.5 mg twice daily and once daily PRN and start lorazepam 0.25 mg twice daily with no PRN orders. The facility nurses failed to remove the PRN order off of resident 21's MAR for nine days. In addition, AP 1 removed 1 lorazepam tablet on two days both around 7:00 p.m., not indicating they were removed with administration to resident 21 and without changing the MAR to prevent ULP from administering lorazepam incorrectly. With one remaining tablet on the narcotic page, AP 1 document she removed it for destruction. On a different narcotic page, AP 1 documented she removed 6 tablets for destruction. Resident 21's medication destruction record completed by AP 1 and signed by AP 1 without a witness nurse indicated she only destroyed 6 tablets of lorazepam 0.5 mg, diverting one tablet.

AP 1 was contacted by phone for an interview but asked the investigator to send her an email interview request. She did not respond to the emailed interview request or to a subpoena.

During an interview, AP 2 said AP 1 trained her on all aspects of ordering and managing medications. AP 2 said that was her first job in assisted living and working with large amounts of narcotics, so at first she did not question her training or the changes in processes with AP 1. AP 2 said she signed the pharmacy delivery slips and placed the medications in the nursing office without opening the delivery bags to count the narcotics because that was how AP 1 trained her. The medication deliveries often arrived mid-afternoon, so AP 2 placed them in her office, unsecured, and went to the mid-afternoon staff meeting. The three nurses had keys to the mediation carts, nurses' office and the nurses' storage room where the overflow mediation cart was kept. AP 2 said the narcotic medications were moved onto the various unit medication carts or moved back to overflow narcotic supplies. There was no record to track the narcotics that were moved back and forth to the nurses' overflow cart because AP 1 told her the nurses all trusted each other. AP 2 said it was a confusing process and AP 1 changed things often. AP 2 said the narcotic records were not always filled out correctly by ULP and only the nurses could correct documentation errors. AP 2 said she performed medication audits to see that the medications matched the narcotic record entries said she saw many of AP 1's initials on record pages for residents with narcotics. AP 2 said she started to notice AP 1 showed up to pass narcotic medications to certain residents around lunchtime, when resident might not be around, and staff did not need help. AP 1 focused on one resident in the care suites unit and on a few in the memory care unit, which had many narcotic prescriptions. AP 2 said she helped pass medications if unit staff needed help, but it was rare. ULP who passed medications were supposed to record in and document under their record-in credentials/initials, not someone else's. AP 2 said she seldom destroyed narcotic mediations because AP 1 did that task. AP 2 said she did not always observe AP 1 dispose of medications; she would hear AP 1 "pop" pills out of

the medication cards and assumed AP 1 was getting rid of them without witnessing her. Destruction of narcotic medications required two staff to observe and sign the forms. AP 2 said when she did destroy medications, she was told to bring them to a blue bin by AP 1, not use the medication destroyer. AP 2 stated she now knows after being taught correctly at new employment about medication receiving, recording narcotics into record and destroying narcotics AP 1 taught her incorrectly. AP 2 said she no longer works at the facility, and she has been interviewed by law enforcement.

During an interview, another nurse said when narcotic medication was moved, documentation in the narcotic records should have matched to show where the medication was taken from and where the medication was added. The nurse said she heard AP 1 tell AP 2 to "sign here, sign here" in the narcotic records prior to monthly audits by corporate staff.

During interviews, multiple staff members said AP 1 would arrive to help pass medications but chose the same few residents each time. Staff members said AP 1 would tell staff to sign off on the MAR that she passed a narcotic medication even though they were supposed to record off and AP 1 needed to record in. Staff members said certain residents who had PRN narcotics would still complain about their pain after they received a scheduled narcotic and a PRN narcotic given by AP 1. Staff stated when AP 2 assisted with a medication pass, AP 2 did sign the MAR herself with her own log in.

During interview, management staff stated after the internal investigation, medication storage was changed to store all medication within the medication carts on each unit and not have an overflow medication cart in the nurse's room. Additionally, the master nurse narcotic book was discontinued, and all medications are accounted for in the individual unit medication narcotic records. The interim director of nursing stated pill caddies are not used at the facility unless in a temporary situation with a new admission and they have a supply of medication from home to use until the pharmacy begins delivering on medication cards.

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.

Inconclusive Financial Exploitation Findings
Resident 4
Resident 4's diagnoses included unspecified dementia and osteoporosis. Resident 4 had prescribed morphine 5 mg every four hours.

Pharmacy delivery records indicated 60 morphine 5 mg tablets were delivered.

Resident 4's individual narcotic record indicated AP 2 received and recorded 60 morphine tablets and documented she put in them in the unit cart. The next day, AP 1 removed and signed for two doses about three hours apart, in the late afternoon and the evening. Another staff member, not AP 1, signed off on the MAR for administration of the two doses of morphine AP 1 removed and signed for in resident 4's narcotic record.

The following day, two doses of morphine were removed and signed for by AP 2 and another staff member in the narcotic record and in the MAR, which left 56 morphine tablets. Later that same day AP 2 removed and signed for the remaining 56 tablets and documented "took out of cart." In another individual narcotic record sheet for resident 4, dated three days after AP 2 removed the 56 tablets from the previous record sheet, someone documented "56" in the "Quantity Received" section at the top of the record page. Yet the first entry by a staff person who removed and signed for one tablet, documented that the count was 26 tablets, not 56 tablets. There were 30 delivered morphine tablets not accounted for.

The next day, AP 2 documented she removed 10 mg of morphine (two 5 mg tablets) and recorded the count at 20 tablets. Another staff member also removed and signed for 10 mg of morphine. The next three doses removed and signed for by staff members indicated only one 5 mg tablet was removed each time and the remaining count was 12 tablets. The following day, AP 2 removed and signed for the 12 morphine tablets and documented "took off cart new order."

Resident 4's hospice provider wrote new orders to discontinue current morphine, start morphine 10 mg 1 tablet every six hours PRN for pain/SOB. The hospice provider gave an ok to administer two morphine 5 mg tablets until the 10 mg tablet doses were delivered.

Pharmacy delivery records indicated 60 morphine 10 mg tablets were delivered on one date.

Resident 4's individual narcotic record indicated AP 2 received and signed for 30 morphine 10 mg tablets and documented "new card." During the next two days the medication count was maintained. Several doses were removed and signed for by staff members. Then AP 2 removed and signed for the remaining 23 tablets and documented "took out of cart." There was no disposition record or documentation on what happened to the 23 morphine tablets.

A second individual narcotic record page indicated AP 2 received and signed for 30 morphine 10 mg tablets. "PRN" was handwritten at the top of the record page. Two days later AP 2 removed and signed for the 30 morphine tablets. There was no medication disposition record or documentation on what happened to the 30 tablets.

A third individual narcotic record page indicated AP 2 received and signed for 53 morphine 10 mg tablets and documented "took out of cart" without any doses dispensed to resident 4. There

was no medication disposition record or documentation on what happened to the 53 morphine tablets.

Resident 4's provider ordered Lyrica 50 mg capsules, 30, give 1 tablet daily for pain. (Pregabalin is the generic drug.)

Pharmacy delivery records indicated 30 pregabalin 50 mg capsules were delivered.

Resident 4's individual narcotic record indicated AP 2 received and signed for 30 pregabalin capsules. The mediation count was maintained for about 11 days, then AP 1 removed and signed for one capsule, which left 19. AP 1 did not sign resident 4's MAR that she gave the capsule. A different staff person signed that they gave a capsule but did not document in the narcotic record. About four hours later that same day, AP 2 documented "took off of cart." AP 1 documented she destroyed 20 pregabalin capsules but there was no second staff witness and signature on the form

Resident 4 had a prescription for 60 lorazepam tablets 0.5 mg, 1 tablet every four hours PRN for anxiety, agitation.

Pharmacy delivery records indicated staff signed for 60 lorazepam 0.5 mg tablets.

Resident 4's individual narcotic record indicated AP 1 and AP 2 both documented they received and signed for 60 lorazepam tablets. About one week later, AP 1 and AP 2 removed the 60 tablets and put in the unit cart. On another individual record page for resident 4, AP 2 documented that she received and signed for 60 lorazepam tablets. At the end of the record page, a staff member documented the medication count for 31 tablets was continued on a third record page. The lorazepam tablet count of 31 was continued on the new record page and the count was maintained until AP 2 removed 1 tablet (which left 16 tablets). The next day AP 2 documented "took out of cart" and entered "0" as the count.

Resident 4's record included a discharge summary after she died in the memory care unit. The summary indicated, "Mediations destroyed, see medication disposition" and was electronically signed by AP 1. There was no disposition form.

Internal investigation records included a written statement by a nurse who indicated she did not record her initials on several of resident 4's medication disposition records and AP 2 was the other staff person who signed those medication disposition records.

During an interview, the nurse said she conducted resident assessments and was not involved with the administration of medications too often since AP 1 had assigned all the medication tasks to AP 2 "and made that known to everyone." During the internal investigation, the nurse said she was shown records with initials that did not look like her way of writing them, but she

could not recall if she signed the disposition forms. Since they were for non-narcotic medications two signatures were not needed. The nurse said she had trusted AP 2.

During an interview, AP 2 said she completed a medication disposition form and handed it to another nurse to sign or initial as the second witness. AP 2 said she was taught by AP 1 how to do medication dispositions and did not forge anyone's initials.

Resident 4's family member said she was not notified about the drug diversion.

Resident 10

Resident 10's diagnoses included metabolic encephalopathy, dementia and Parkinson's disease. Resident 10 is deceased.

Resident 10's narcotic record page indicated he had a prescription for clonazepam 0.5 mg tablets. Someone documented 30 tablets received. The medication count was maintained until 17 tablets were left. There was no further record activity and the page was crossed off.

No pharmacy delivery records were provided. No MAR for that month was provided.

Resident 10's narcotic record page indicated he had a prescription for lorazepam 1 mg tablets. AP 2 signed 30 tablets were received and documented she put them in the unit cart. A few days later AP 1 removed the remaining 25 tablets and wrote "D/C" followed by illegible writing or an illegible signature. AP 1 completed a medication disposition form for 42 morphine tabs, 26 morphine tabs, 25 lorazepam tabs. There was no second witness signature.

Resident 10's narcotic record indicated he had a prescription for morphine 2.5 mg tablets. AP 2 received and signed for 3 tablets. A few days later, someone documented "remove DC." The signature was illegible.

AP 1 completed a medication disposition form for 42 morphine tablets, 26 morphine tablets, and 25 lorazepam tablets. The prescription number for the morphine tablets was the same on the disposition record and the narcotic record page.

Resident 12

Resident 12's diagnoses included osteoarthritis. Resident 12's physician orders included an order for tramadol (controlled pain medication) 50 mg, take a half tablet (25 mg) once daily PRN. Pharmacy delivery records indicated resident 12 had a tramadol 50 mg delivery of 7 tablets, however the signature of delivery receipt was not found in the records. AP 2 recorded the fully supply into the master narcotic book and then transferred the supply into the unit narcotic book. Resident 12 received three PRN administrations and 5 ½ tablets remained. The narcotic page a line struck through the record and no disposition of medication record was completed. The facility internal investigation indicated the 5 ½ tablets were missing.

Resident 19

Resident 19's diagnoses included degenerative disc disease. Resident 19's physician orders included an order for oxycodone 2.5 mg as needed for pain. Resident 19's pharmacy delivery records indicated 90 half tablets of oxycodone 5 mg (2.5mg doses) were delivered. Review of resident 19's MAR and narcotic records indicated 60 doses were accounted for with administration. AP1 and AP2 recorded 60 doses into the narcotic record when the oxycodone was received, however 30 doses (15 total tablets) were not recorded into the narcotic b[illegible] and pharmacy records lacked a signature of who received the medication delivery. It is inconclusive who took the 15 tablets of oxycodone.

The facility did not provide an order for lorazepam for resident 19. Resident 19's MAR included conflicting orders for lorazepam. Transcribed orders changed from 0.25 mg twice a day to and 0.5 mg twice a day mid-month, but then changed back to 0.25 mg twice a day the next day. Pharmacy delivery records indicated the same date as the transcription changed to lorazepam 0.5 mg twice a day, the pharmacy delivered two cards of lorazepam 0.5 mg, 30 tablets. One prescription card was accounted for with review of narcotic records compared to resident 19's MAR. The second card had 7 doses of lorazepam 0.5 mg administered and the remaining 23 were unaccounted for with no signature of removal from the narcotic record, no medication destruction record and no recording in 15 of the tablets upon delivery from the pharmacy into the narcotic record.

Resident 20

Resident 20's diagnoses included Parkinson's disease, atrial fibrillation, Type 2 diabetes and kidney disease.

Resident 20 had a prescription for lorazepam 0.5 mg, 30 tablets, give 1 tablet every four hours PRN for anxiety/agitation.

Pharmacy delivery records indicated resident 20 received 30 lorazepam 0.5 mg tablets.

A narcotic record page for resident 20 indicated AP 2 received and signed for 30 tablets and documented she put them in the unit cart. Over the next few days, four doses were given, then AP 2 documented she put them in nurse cart and removed the remaining 26 tablets. A narcotic record page for resident 20 indicated AP 1 and AP 2 received and signed for 26 tablets. The page was crossed out. There was no other documentation or disposition record.

Pharmacy records indicated resident 20 received a 60 tablet and a 30 tablet supply of oxycodone 2.5 mg tablets.

Resident 20's individual narcotic record page indicated AP 1 and AP 2 received and signed for 13 oxycodone tablets and put in the unit cart. The page was crossed off and on the right margin destroy was written. There was no disposition form.

There was an additional record page with a different oxycodone prescription number that indicated 36 oxycodone (no details) were received and signed for by AP 1 and AP 2 and “medication D/C - order” was written. There was no pharmacy delivery slip, MARs or disposition forms provided.

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.

Not Substantiated Financial Exploitation Findings
Resident 15
Resident 15’s diagnoses included Parkinson’s disease and dementia. Resident 15’s medication orders included tramadol (pain medication) 50 mg three times daily. Pharmacy delivery records compared with resident 15’s MAR and narcotic records indicated resident 15 received her scheduled doses of tramadol and were accounted for.

Resident 17
Resident 17’s diagnoses included pain. Resident 17’s MAR included an order for pregabalin (controlled medication used for nerve pain) 75 mg scheduled twice a day. Pharmacy delivery records compared with resident 17’s MAR and narcotic records indicated resident 17 received his scheduled doses of pregabalin and were accounted for. Resident 17’s progress notes indicated the resident 17 stopped receiving medication management services from the facility and began receiving home care services for medication setup and medication management. The same day as the progress note, the narcotic record indicated resident 17’s remaining supply of pregabalin was removed, signed by two nurses (AP 2 and a second nurse), and given to resident 17.

In conclusion, the Minnesota Department of Health determined financial exploitation was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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;

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) AP 1 did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

AP 1 did not provide proper training and/or supervision of staff.

The facility did not provide proper supervision of AP 1.

The facility provided adequate staffing levels.

AP 1 and AP 2 failed to follow the facility directive and/or policies and procedures.

(3) AP 1 and AP 2 failed to follow professional standards and/or exercise professional judgement.

AP 1 and AP 2 failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No. Several residents are deceased or moved. Due to the length of time that passed since facility discovered, residents may not recall incidents and many had diagnoses that impacted their cognition.

Family/Responsible Party interviewed: No. Family had no awareness of the drug diversion, but families were contacted.

Alleged Perpetrator interviewed: No, AP 1 declined a phone call, and did not reply to an email interview request and a subpoena. Yes, AP 2 interviewed.

Action taken by facility:
The facility conducted an internal investigation and contacted law enforcement. The facility changed their medication administration practices by changing log-ins and removed overflow storage from the nurses room. AP 1 no longer at facility. AP 2 no longer at 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.

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

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
Ramsey County Attorney
Maplewood City Attorney
Maplewood Police Department
Minnesota Board of Nursing
Drug Enforcement Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39485	A. BUILDING: _____ B. WING _____	C 11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY GARDENS	1440 COUNTY ROAD C EAST MAPLEWOOD, MN 55109

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER 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: HL394859340C/HL394856281M On November 25, 2024, 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 62 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL394859340C/HL394856281M, tag identification 02360.	0 000	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. 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 Residents have the right to be free from physical,	02360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39485	A. BUILDING: _____ B. WING _____	C 11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02360	Continued From page 1 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 14 of 21 residents reviewed (R1, R2, R3, R5, R6, R7, R8, R9, R11, R13, R14, R16, R18, R21) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and individual persons were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		