Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL200961080M
Compliance #: HL200961683C

Date Concluded: October 3, 2022

Name, Address, and County of Licensee Investigated:
Northfield Parkview Inc.
910 Cannon Valley Drive
Northfield, MN 55057
Rice County

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

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The resident was financially exploited when the alleged perpetrator (AP) took tablets of the resident's narcotic medication for her personal use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP admitted to taking the resident's hydrocodone tablets (a narcotic medication) and replacing them with unmarked pills.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medication administration records, narcotic medication counts, staff training records, policies and procedures, and the facility internal investigation. The investigator toured the facility and observed staff administer medications.

The resident resided in an assisted living facility and had diagnoses including dementia and chronic pain syndrome. The resident's service plan included assistance with medication management, shower assistance, assistance with oral cares, housekeeping, and meals. The resident's assessment indicated functional and cognitive impairments, with vulnerabilities to abuse and financial exploitation.

During an interview, a staff member stated she witnessed the AP cutting tablets of medication out of a bubble pack. She was unsure what the AP was doing, as medications were normally kept in their original containers until they were administered to a resident. Later in the shift a colleague called the staff member to a secluded garbage room. There were empty bubble packs of hydrocodone belonging to the resident in a garbage container. The staff member stated bubble packs would never be thrown directly into the trash but would instead be shredded after use to protect privacy of the resident. The staff member and her colleague collected the bubble packs and went to count the resident's hydrocodone. The colleague counted the resident's hydrocodone (which was stored in a bottle from the resident's pharmacy) and the amount of hydrocodone in the bottle did not match the number documented in the narcotic medication logbook. The staff member's colleague also said the pills in the bottle did not appear to match each other and they reported their concerns to facility leadership.

When interviewed, a nurse stated she was informed by staff the resident's hydrocodone count was off, so she reviewed the resident's medication with three other staff members. The nurse counted the hydrocodone tablets and noticed the tablets in the bottle had different appearances. The bottle was labeled to contain sixty (60) tablets but contained 63 pills. Three tablets in the bottle were scored and marked with the appropriate hydrocodone inscription. The remaining sixty tablets lacked scoring, had no inscriptions, and were also a slightly different shape than the verified hydrocodone tablets. The nurse consulted the pharmacist, who stated the hydrocodone would always be scored and inscribed. If there were tablets lacking those characteristics, it would not be an FDA-approved medication, and was likely a nutritional supplement. The nurse stated a staff member reported she saw the AP coming out of the resident's room earlier in the shift and thought it was strange because the AP did not work on that side of the building, nor did she manage that resident's medications.

During an interview, a management staff stated three staff members informed him of suspected medication diversion. He went with the nurse to observe her complete a count of the hydrocodone. After it was determined the hydrocodone count was off and most of the tablets did not appear to be hydrocodone, he and another facility leader interviewed the AP. During that interview, the AP admitted to taking the resident's hydrocodone and replacing it with the unmarked tablets.

The AP declined interview with the investigator.

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.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9

(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, the AP declined to be interviewed.

Action taken by facility:
The facility conducted an internal investigation and provided training to staff regarding medication administration. The AP no longer works for the facility.

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html
If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4890 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
Rice County Attorney
Northfield City Attorney
Northfield Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20096	A. BUILDING: _____ B. WING _____	C 09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHFIELD PARKVIEW INC	910 CANNON VALLEY DRIVE NORTHFIELD, MN 55057

(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: #HL200961683C/#H200961080M On September 7, 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 67 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL200961683C/#HL200961080M, tag identification 0650, 1460, and 2360.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 650 SS=F	144G.42 Subd. 8 Employee records	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20096	A. BUILDING: _____ B. WING _____	C 09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHFIELD PARKVIEW INC	910 CANNON VALLEY DRIVE NORTHFIELD, MN 55057

(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
0 650	Continued From page 1 (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure the employee record contained the required content for three of three employees reviewed, registered nurse (RN)-H, health unit coordinator (HUC)-C, and unlicensed personnel (ULP)-G with records reviewed. This had the	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20096	A. BUILDING: _____ B. WING _____	C 09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHFIELD PARKVIEW INC	910 CANNON VALLEY DRIVE NORTHFIELD, MN 55057

(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
0 650	Continued From page 2 potential to affect all residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-H was hired on February 14, 2022, to provide assisted living services to residents. HUC-C was hired on December 12, 2016, to provide assisted living services to residents. ULP-G was hired on April 8, 2021, to provide assisted living services to residents. All three employee records lacked evidence of 144G training in accordance with the statutes instituted August 1, 2021 On September 7, 2022, at 2:30 p.m., the licensed assisted living director (LALD)-D stated staff had completed required training and would the facility would provide the documentation. No further information was provided. The facility's policy titled Assisted Living & Assisted Living with Memory Care Orientation-All Staff dated August 1, 2021, indicated all newly hired staff will receive orientation and training on topics required for assisted living organizations. TIME PERIOD FOR CORRECTION: Fourteen	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20096	A. BUILDING: _____ B. WING _____	C 09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHFIELD PARKVIEW INC	910 CANNON VALLEY DRIVE NORTHFIELD, MN 55057

(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
0 650	Continued From page 3 (14) days.	0 650		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide staff orientation to assisted living licensing requirements and regulations for one of three employees unlicensed personnel (ULP)-G with records reviewed. This had the potential to affect all residents receiving services from the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-G was hired on April 28, 2021, to provide assisted living services to the facility's residents.	01460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20096	A. BUILDING: _____ B. WING _____	C 09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHFIELD PARKVIEW INC	910 CANNON VALLEY DRIVE NORTHFIELD, MN 55057

(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
01460	Continued From page 4 On September 7, 2021, at 10:00 a.m., ULP-G was observed providing direct care services for a resident, which included administering scheduled morning medications. ULP-G's employee record lacked documentation to indicate the assisted living facility training requirements were completed in accordance with 144G statutes. On September 7, 2022, at 2:30 p.m., the licensed assisted living director (LALD)-D stated staff had been oriented to assisted living statutes and would provide the documentation. No further information was provided. A policy titled Assisted Living & Assisted Living with Memory Care Orientation-All Staff dated August 1, 2022, stated all employees must complete an orientation to assisted living facility licensing requirements and regulations. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	01460		
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 the residents (R1) was free from maltreatment. R1 was financially exploited.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20096	A. BUILDING: _____ B. WING _____	C 09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHFIELD PARKVIEW INC	910 CANNON VALLEY DRIVE NORTHFIELD, MN 55057

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02360	Continued From page 5 Findings include: On September 7, 2022, the Minnesota Department of Health (MDH) issued a determination that drug diversion occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		