Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202195764M
Compliance #: HL202198132C

Date Concluded: October 17, 2024

Name, Address, and County of Licensee Investigated:
Lake Minnetonka Shores
4559 Shoreline Drive 416
Spring Park, MN 55364
Hennepin County

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

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Inconclusive

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

Initial Investigation Allegation(s):
The resident was financially exploited by drug diversion when the alleged perpetrator (AP) tampered with and diverted 6 narcotic hydrocodone-acetaminophen tablets (Norco) for her own use and replaced them with another non-controlled medication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation by drug diversion by the AP was inconclusive. The resident's Norco was tampered with and diverted in a time frame of 6 days, during that time at least 12 other staff had access to the medication. As a result, it could not be determined if the AP or another staff tampered with and diverted the resident's Norco.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the resident's family. The investigation included review of the resident record(s), pharmacy records, facility internal investigation, facility surveillance videos, photographs, facility incident reports,

personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed resident's and staff in the facility, and the facilities process to monitor and prevent the diversion of controlled drugs.

The resident resided in an assisted living facility with diagnoses including osteoarthritis, degenerative joint disease, and acute pain left knee.

The resident's 90-day assessment indicated the resident received medication management and administration services from the facility. The assessment indicated the resident had intermittent pain in her left humorous and back, and chronic pain due to lupus and Lyme's disease. The assessment indicated the resident utilized controlled drug narcotic pain medication Norco 7.5/325 milligrams (mg) twice daily. The resident assessment indicated interventions in place to prevent diversion included a double locked med cupboard, witnessed administration of all controlled drugs, and medication counting by unlicensed personnel (ULP) staff and/ or nursing staff.

A facility occurrence report indicated the residents bubble pack in room [16] containing controlled drug hydrocodone-acetaminophen (Norco) had 6 pills that were removed and replaced with hydroxychloroquine tablets (a similar looking tablet). The report indicated the resident's bubble pack appeared to be tampered with. The facility investigation included photographs of the cards which showed the back of the resident's Norco bubble pack, with 6 tablets punched out and replaced with hydroxychloroquine, then taped over with scotch tape and paper tape.

The facility investigation indicated leadership staff reviewed video surveillance footage which showed the AP had removed a handful of bubble pack medication cards from the resident in room [20]. The investigation indicated this was suspicious behavior because of the number of times the AP entered the resident's room, and a ULP should not remove any cards from a resident room unless they were empty. The facility investigation indicated a nurse verified the residents Norco was intact and the count was correct on August 30 and indicated the diversion occurred sometime between August 30 and September 3.

A police report indicated the resident's Norco tablets appeared to have been opened and a piece of tape placed on the back to reseal it. The pills were identified on Drugs.com as 200 mg of Hydroxychloroquine, a noncontrolled drug. The report indicated the AP had unusual behavior and facility leadership suspected the AP took hydroxychloroquine pills from the resident in room [20], then tampered with and diverted 6 Norco tablets from the resident in [16]. The police report indicated the diversion could have occurred over a time span of 6 days. The report indicated the AP agreed to a voluntary DNA sample. The report indicated there was not enough probable cause to charge the AP, and the case was closed.

A review of the AP's personnel files indicated the AP was employed by the facility for 7 years with no pattern or conduct concerns for potential diversion.

A review of the resident's medication administration record (MAR), and controlled drug witness report indicated the AP had administered the controlled drug as prescribed 3 times during the time frame when the diversion occurred. The AP administrations were all witnessed by another staff indicating no concerns of diversion occurred during the AP's administration times documented. The resident MAR and controlled drug report indicated another ULP staff not the AP had 2 documented administrations to the resident that were not witnessed or verified by another staff.

The resident's MAR, controlled drug witness report, and facility schedules indicated at least 12 other employees from August 30 to September 3, also had access to the resident's Norco during the time frame when the diversion occurred. As a result, there is no way to know who tampered with and diverted the resident's Norco.

During email communication facility leadership indicated a resident would have about 6 days of medications remaining in each bubble pack card when a refill occurred. Leadership indicated when the cards were empty staff should remove the empty cards from the resident's med cupboard. Leadership indicated although the AP was observed removing a handful of cards from room [20], and the resident in [20] was prescribed hydroxychloroquine, the inscription on her hydroxychloroquine pills did not match the inscription of all the hydroxychloroquine pills found in [16]'s tampered Norco cards. Leadership indicated when the resident in [20]'s cards were reviewed no pills were unaccounted for, and there did not appear to be any medication discrepancies. As a result, there was no indication the hydroxychloroquine found in the resident in [16]'s Norco bubble pack were from the resident's supply in [20]. In addition, facility leadership indicated the AP was never witnessed taking any cards out of room [16], and the tampering and diversion occurred within room [16] where there was no video evidence.

A review of the facilities video surveillance showed the AP remove numerous (at least 6) bubble pack cards from room [20]. The video was observed at a slowed rate and zoomed which showed the cards removed by the AP appeared to be empty. The AP's body language and conduct appeared appropriate, and the AP did not appear to attempt to conceal removal of the bubble pack cards from room [20].

A pharmacy delivery record for the resident in [20] indicated a refill of the resident's medications was completed on August 28, which included 10 medications in 13 bubble pack cards (6 days prior to when the AP was observed on video surveillance remove at least 6 cards from the resident's room in [20]). The MAR indicated the resident in [20] had 8 medications prescribed for administration on the AP's shift. The resident's medication refill and removal of bubble pack cards from room [20], aligns with when the resident's refill and removal of empty cards would have likely occurred.

When interviewed the AP denied any wrongdoing and stated she followed protocol and made sure the count and administration of the resident's Norco was always witnessed by another staff. The AP stated she had not noted any concerns with the medication count or bubble pack cards with any of her counts or administrations. The AP stated she gave law enforcement her DNA and permission to search her personal property for the resident's narcotics because she had done nothing wrong and had nothing to hide. The AP stated the only reason she would ever have removed cards from [20] was if they were empty and indicated that resident had many cards that were empty and needed removal at the same time during her shift.

In conclusion, the Minnesota Department of Health determined financial exploitation by drug diversion by the AP was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes, attempted
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility reported the potential diversion, investigated the incident, re-educated all staff to identify and report potential diversion, and nursing audits of controlled drug counts were increased to prevent recurrence.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20219	A. BUILDING: _____ B. WING _____	C 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MINNETONKA SHORES	4559 SHORELINE DRIVE SPRING PARK, MN 55384

(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 On September 25, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL202195764M/#HL202198132C. No correction orders are issued.	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.	