Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202578024M
Compliance #: HL202575062C

Date Concluded: October 2, 2023

Name, Address, and County of Licensee Investigated:
Assisted Living at North Ridge
5500 Boone Avenue North
New Hope, MN 55428
Hennepin County

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

Evaluator's Name:
Katie Germann, RN, Special Investigator

Finding: Substantiated, facility 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 facility financially exploited a resident when the resident's narcotic medication went missing from the storage compartment located at the facility's front desk.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The facility was responsible for the maltreatment. The resident's hydrocodone (a narcotic medication) was delivered to the facility by the pharmacy and signed for by facility staff. The medication was then placed in a locked cupboard at the front desk, and the key to the cupboard was left in the open and unattended where anyone could have accessed it. The facility was unable to locate the residents 120 hydrocodone the pharmacy delivered to the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, facility policies and procedures, staff schedules, and staff training.

The resident resided in an assisted living facility. The resident's diagnoses included fibromyalgia. The resident's service plan included assistance with dressing, grooming, toileting, transferring, and medication management and administration. The resident's assessment indicated the resident had decreased range of motion in her arms due to chronic pain.

A facility investigation of the incident indicates the resident's hydrocodone was delivered to the facility from the pharmacy at 9:16 p.m. The delivery included the resident's hydrocodone in a white bag and other medications for other residents in several black bags. The staff at the front desk remembered signing for receipt of the medications. The investigation indicated the front desk staff put the medications in a locked cupboard located at the front desk and placed the key in a wire basket located on top of the front desk. The front desk staff left the front desk unattended on two occasions prior to leaving for the evening at 10:00 p.m. The nurse for the next shift came to collect the medications from the locked cupboard at the start of the shift. The investigation indicated when the nurse arrived at the front desk, the desk was unattended. The nurse reported there were black bags of medication in the cupboard, but no white bag. The facility staff did not realize the narcotics were missing for six days because the day after the medication arrived, the resident was sent to the hospital and did not arrive back at the facility until five days later. When the resident returned from the hospital, she asked for hydrocodone for pain. The staff were unable to locate the hydrocodone and it was discovered the medication was missing. The investigative report indicated several facility staff were interviewed and no one knew where the missing hydrocodone was. The investigation indicated the current process for narcotic management was not secure and it could not be determined where or how the hydrocodone went missing.

A facility incident report indicated the resident asked staff for hydrocodone for pain. The nursing staff were unable to locate the medication and contacted the pharmacy to inquire about getting the resident hydrocodone. The pharmacy stated the hydrocodone was delivered six days earlier and a facility staff signed they received the hydrocodone. The facility staff searched for the hydrocodone but were unable to locate the medication.

During interview the front desk staff stated she signed for the hydrocodone when it arrived and placed the medications in the locked cupboard at the front desk. She then left the front desk on two occasions, leaving the area unattended. The front desk staff stated she placed the key in a wire basket on top of the desk. The front desk staff stated most of the facility staff knew where the key was located and what the key was for. The front desk staff stated she voluntarily took a drug test, and it did not show she had hydrocodone in her system. She did not see anyone near her desk or anything out of the ordinary on her shift. The front desk staff stated she did not know where the hydrocodone went.

During interview a facility nurse stated she arrived at the facility at 10:00 p.m. the evening of the incident. The nurse stated she completed some tasks and went to collect the medications from the front desk at approximately 10:30 p.m. There were no staff at the front desk when she took the key from on top of the desk and collected the medications. The nurse stated there were no hydrocodone in the medications she collected from the front desk.

During an interview another facility nurse stated the process for receiving medications from the pharmacy was to place the medications in the locked cupboard at the front desk. The nurse would collect the medications, enter them into the medical chart and narcotic tracking book and place the medications into a bin for the medication passers to distribute to the medication carts. The nurse stated the key for the medication cupboard was kept in a basket on top of the front desk on a yellow key chain. The staff knew where the key was and what the key was for. The nurse stated there was no way to determine who took the hydrocodone because the key for the medication was left unattended at the front desk.

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

Vulnerable Adult interviewed: No
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility changed the process of the handling of narcotic medications and educated the staff on proper handling of narcotic medications.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
New Hope City Attorney
New Hope Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	C 08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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 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: #HL202573946C/ #HL202577384M #HL202575062C/ #HL202578024M #HL202571923C/ #HL202576243M On August 23, 2023, 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 121 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL202573946C/ #HL202577384M, and #HL202575062C/#HL202578024M tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 1 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure two of two residents (R1 and R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		