Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment #: HL217803721M

Compliance #: HL217804037C

Date Concluded: August 19, 2024

Name, Address, and County of Licensee Investigated:
The Pines Assisted Living
400 West 67th Street
Richfield, MN 55423
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Maerin Renee, 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 perpetrator (AP) financially exploited the resident when the AP stole hydrocodone (narcotic pain medication) from the resident's personal supply.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The resident was missing approximately 30 hydrocodone. The AP was responsible for managing resident medications in the facility. Based on a preponderance of evidence, it was determined the AP took the residents hydrocodone for her own personal use.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, a family

member, and guardian. The investigation included review of the resident records, pharmacy and medication records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed staff interactions with residents and the facility medication system.

The resident resided in an assisted living facility. The resident's diagnoses included chronic pain and liver disease. The resident's services included assistance with medication management, catheter care, meals, housekeeping, and laundry. The resident's assessment indicated the resident was vulnerable to financial exploitation.

The facility incident report indicated two staff counted narcotic medications at shift change and the narcotic count was accurate. One staff told the AP, who was responsible for managing medications at the facility, the resident only had one tablet of hydrocodone left. The resident was prescribed one tablet every eight hours. The AP told the staff she ordered more hydrocodone from the pharmacy. Later in the shift, the caregiver called the on-call nurse to report the resident was out of hydrocodone. The pharmacy told the on-call nurse the resident should still have a 28-day supply. The pharmacy sent the hydrocodone to the facility the previous month, and the card of hydrocodone should have been documented in the narcotic logbook as received from the pharmacy. However, the AP had not documented how many cards of hydrocodone were received from the pharmacy.

Facility documents indicated the following day, staff searched for the resident's card of hydrocodone and could not find it. The AP said she had no idea where the card could have gone. The facility procedure was only one card of a resident's narcotic medication was placed in the narcotic box at a time. Additional cards were locked in the AP's desk drawer. Both the AP's office and desk drawer were locked when the AP was off duty. When interviewed, the AP said, she didn't know what happened, said there was a pharmacy mix-up, and stated she was, "lazy when it comes to narcs." Leadership discovered the narcotic logbook in the AP's office had not been reconciled for several months. There were no counts of the resident's hydrocodone and pages had been ripped out of the book.

When interviewed, the AP did not say she took the medication, however, she stated she "needed help." The AP stated she should have let the facility know she had a problem and needed help. The AP said she had an appointment at a chemical dependency treatment center and had retained a defense attorney. The card of hydrocodone was never found, the AP was placed on administrative leave, and the facility filed a police report.

The police report indicated facility leadership reported the resident's card of hydrocodone was missing, which contained 30 pills. The AP oversaw all the medications in the facility. The AP gave medications to facility caregivers, who would in turn administer the medications to the residents. The caregiver working at the time of the incident was never given the hydrocodone for the resident, and the AP was working the day the hydrocodone went missing. Facility leadership said the AP never admitted to taking the hydrocodone but alluded to it by saying she

had, “a problem and would love some help.” Leadership did not wish to press charges and the case was closed.

The pharmacy packing slip from the previous month indicated the resident received 168 tablets of hydrocodone. The packing slip was not signed or dated by the receiving staff.

The narcotic logbook managed by the AP indicated the AP stopped consistently tracking narcotic medications three months before the resident’s hydrocodone went missing. One of the final pages in the book available for review lacked details such as staff signatures and the disposition of the hydrocodone. The complete log was unable to be reviewed as the last five pages of the resident’s hydrocodone log were ripped out of the book.

When interviewed, a supervisor said a caregiver notified the on-call nurse that he could not find more of the resident’s hydrocodone. After it was determined with the pharmacy that the resident should still have 30 tablets left, the supervisor asked the AP if she knew where the card of hydrocodone was. The AP said there should still be another card of hydrocodone available for the resident. The supervisor instructed the AP and another nurse to follow up, and to also pursue a stat (immediate) order to get the resident more hydrocodone. The supervisor believed the resident missed two or three doses of her hydrocodone. The supervisor said nursing duties were divided up and the AP was the sole individual responsible for resident medications in the facility. When the pharmacy delivered a narcotic medication, the AP was to log it into the nurse narcotic logbook. If more than one card of narcotic medication was ordered, one card would be given to caregivers to administer to the resident, and the other cards would be stored locked in the AP’s office. It was the AP’s responsibility to reconcile the nurse logbook (the recorded deliveries) with the caregiver logbook (that recorded administration of narcotic medications to the residents).

The supervisor verified the caregiver turned in the empty card of hydrocodone, so she had the AP and another nurse follow up on the missing card. The facility had received three cards of hydrocodone for the resident, so they should have been labeled 1/3, 2/3, and 3/3. The supervisor instructed the AP and nurse to find the empty card and see what it was numbered. Neither one of them were able to find the card the caregiver turned in. The supervisor stated the AP arrived two hours earlier than the other nurse, so there was a gap in time before the other nurse was able to join the AP in the search. The AP said she had stopped labeling the cards, so the missing empty card would not have been labeled. As the AP and another nurse attempted to reconcile the two narcotic logbooks, it was found that prescription numbers did not match, and from page to page it was difficult to follow the trail of the resident’s hydrocodone. It was then the other nurse and the supervisor discovered several pages of the narcotic logbook had been ripped out, and those pages coincided with the missing card of hydrocodone. The supervisor said at that point there was no way to go back and check how much hydrocodone there should have been or which card was missing. The only documentation the facility had that the medication had been delivered was the pharmacy slip.

The supervisor said she talked to the AP regarding the missing hydrocodone and at first the AP said she did not know where the card was, then the AP said the caregivers were out to get the nurses. The supervisor said she wanted the AP to be honest with her. The AP said she had started to fall behind, so she stopped labeling the cards, stopped documenting them in the narcotic logbook, and stopped having a witness sign the logbook for deliveries and disposition to the caregivers. The supervisor told the AP it appeared that everything was pointing toward the AP and she needed to take responsibility. The supervisor told the AP if she took the cards, leadership could get her help if that is what she needed. The AP stated she had a problem and would like to get help, however, she wanted to obtain legal representation before answering any more questions. The AP retained a lawyer and entered a chemical dependency treatment center. The AP told the supervisor she had been “doing it” a while and needed help. The supervisor asked the AP if she could say she took the cards, but the AP never said yes or no. The AP responded with, “You already know.”

When interviewed, the AP said she was very sick at the time and not in her right state of mind, so she did not know what happened to the missing card of hydrocodone.

When interviewed, a family member said she had concerns about the resident’s refills in the past, but communication with the facility was difficult.

When interviewed, the resident said she could not remember the specific incident, but there were a couple times when her pain medication was not available. The resident said she was in extreme pain when her pain medication was unavailable, and it was hard to get her pain to a manageable level when she missed doses.

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: Yes.

Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation and filed a police report. The AP is no longer employed at the 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.

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
Hennepin County Attorney
Richfield City Attorney
Richfield 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
	21780	A. BUILDING: _____ B. WING _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ASSISTED LIVING	400 WEST 67TH STREET RICHFIELD, MN 55423

(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: #HL217804037C/#HL217803721M On July 30, 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 55 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL217804037C/ #HL217803721M, 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 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		