Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL259193545M
Compliance #: HL259193863C

Date Concluded:

Name, Address, and County of Licensee Investigated:
Centennial Villa
500 Park Street East
Annandale, Minnesota 55302
Wright County

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

Evaluator's Name:
Katherine Barnhardt 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 resident #1 and resident #2 when the AP took Morphine (opioid narcotic) from the residents' medication supply.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation by drug diversion was substantiated. The AP was responsible for the maltreatment. The AP took Morphine tablets from resident #1 and resident #2's medication supply while working the overnight shift.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, a family member, a resident and attempted to interview the AP. The investigation included review of the resident #1 and resident #2's record, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report and related facility policy and procedures. The investigator observed unlicensed staff interact with residents and medications.

Resident #1 resided in an assisted living unit. Resident #1's diagnoses included opioid (narcotic) dependence, anxiety, and chronic pain. Resident #1's service plan included assistance with medication management and administration. Resident #1 was oriented to person, place, and time, gave accurate information consistently and experienced chronic pain. Resident #1's provider order included Morphine 15 (milligrams) tablet six times a day and one dose as needed for pain and shortness of breath.

Resident #2 resided in an assisted living memory care unit. Resident #2's diagnoses included dementia, gout of the right ankle and foot, and left shoulder pain. Resident #2's service plan included assistance with medication management and administration. Resident #2's assessment indicated the resident had severe orientation deficits, had difficulty communicating and experienced intermittent pain. Resident #2' provider order included Morphine 5 mg tablet every four hours as needed.

Review of resident #1's narcotic administration record and the bubble packs (foil backed cardboard pill organizer) containing Morphine included signatures, dates and times for staff who administered resident #1's narcotic medications. One medication pack had a slit cut into one of the bubbles containing the Morphine tablet and an unknown pill taped in its place. The replacement pill (later identified as an antipsychotic medication) had been taped into the cut area that should have contained Morphine.

Review of resident #2's narcotic administration record included signatures, dates and times for staff who administered Morphine for resident #2. The narcotic log indicated the resident did not routinely use the Morphine; however, two doses had been administered during the same night shift. One dose was signed out as administered in the narcotic log, however, was not documented in the electronic medication record as administered. The medication card was not dated or initialed by a staff member for the second dose according to facility policy. Unlicensed personnel whose name appeared on the narcotic log twice during night shift reported the second dose documented was a forged signature. The unlicensed personnel whose name was signed on the medication log did not work the shift it was signed out.

During a facility internal investigation, management compared the staff work schedule with resident #1 and resident #2's medication administration record. Licensed staff reviewed the controlled substance records of when and who last reconciled and verified the controlled medications. Facility policy was two staff count and verify all controlled substances on the four medication carts each shift change. That morning shift, unlicensed personnel verified the number of pills written in the narcotic log as the AP counted the number of pills remaining in the bubble packs on two of four medication carts. The AP stated to the unlicensed personnel she was unable to count or verify narcotics on the two remaining medication carts due to a family emergency. The AP left the building. The unlicensed personnel and another unlicensed personnel counted and verified the remaining two medication carts that did not have missing Morphine. During the afternoon shift change, when the first unlicensed personnel reversed her

position for the count and counted the actual pills to oncoming staff, the unlicensed personnel identified the discrepancy. The unlicensed personnel noted a missing Morphine signed out of one medication cart with a forged signature and an unknown pill taped into a bubble pack of Morphine in another medication cart. The facility's investigation determined the Morphine was taken during the previous overnight shift when the AP worked by herself on the medication carts and had sole control of the medication carts. A signature was entered into the narcotic log on one medication cart for a staff member that was not working the night the signature was entered.

A law enforcement report indicated the AP worked the previous night shift when the Morphine tablets were found to be missing from the medication carts the AP solely managed. The facility had no incidents involving controlled substances prior to or after the AP worked. The report concluded two Morphine tablets were unaccounted for and a signature was forged during the night shift worked by the AP. The law enforcement report noted the AP had a prior history of drug related offenses and reached out to the AP for an interview. The AP declined an interview with law enforcement.

During an interview, the unlicensed personnel stated when she came on shift, she was greeted by the AP from a temporary staffing agency she had never met. The AP and the unlicensed personnel counted narcotics on two of the facility's four medication carts. The unlicensed staff stated she verified the numbers written in the narcotic log as the AP counted the pills in the bubble packs. After counting medications on two carts, the AP told the unlicensed personnel she was unable to count and verify on the other two carts due to an emergency and the AP left the building. The unlicensed personnel stated for the afternoon narcotic count she reversed positions and according to facility policy counted the bubble packs while the oncoming shift verified the numbers written in the narcotic logbook. The unlicensed personnel noted a missing narcotic signed out of one medication cart with a forged signature and an unknown pill taped into a controlled substance pack in another cart. Additionally, the unlicensed personnel stated the AP asked a co-worker if cameras were present on the medication carts and the unlicensed personnel thought that was "odd".

During an interview, licensed staff stated the unlicensed personnel came to them with a narcotic discrepancy found during resident #1 and resident #2's narcotic count. Licensed staff stated following the report of missing narcotics, the facility reviewed narcotic medication records, reviewed staff schedules, spoke with multiple staff, and audited medication carts. The licensed staff stated the two missing Morphine tablets had been identified as taken on the overnight shift worked by the AP and the AP was the only staff member who had access to the controlled substances on the night shift.

In conclusion, the Minnesota Department of Health determined financial exploitation by drug diversion 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: Attempted but declined an interview.

Action taken by facility:
The facility conducted an internal investigation and terminated the AP’s employment.

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
Wright County Attorney
Annandale City Attorney
Annandale Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25919	A. BUILDING: _____ B. WING _____	C 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL VILLA	500 PARK STREET EAST ANNANDALE, MN 55302

(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 LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.01 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL259191600M/HL259199164C #HL259193545M/ HL259193863C On July 16, 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 123 residents receiving services under the assisted living with dementia license. The following correction order is issued for # HL259193545M/ HL259193863C, tag identification 2360 .	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		

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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 two of two resident(s) reviewed (R1, R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred. An individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment reports for details.	02360	No plan of correction is required for this tag.	