*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL29446001M
**Compliance #:** HL29446002C

**Date Concluded:** February 8, 2022

**Name, Address, and County of Licensee Investigated:**
Heritage Pointe Senior Living
207 North 4th St
Marshall, MN 56258
Lyon County

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

**Evaluator's Name:**
Lisa Coil, 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.

**Allegation(s):**
It is alleged: The alleged perpetrator (AP) financially exploited the resident when the AP took narcotics from the resident.

**Investigative Findings and Conclusion:**
Financial exploitation was substantiated. The AP was responsible for the maltreatment. Although the AP was not assigned to the resident's cares, video surveillance showed the AP entering the resident's room where the resident's medications were stored. A short time later, the facility discovered the resident's narcotic book had been altered and narcotics missing. Further investigation indicated the AP diverted medications on multiple occasions.

The investigation included interviews with facility staff members, including nursing staff and unlicensed staff. The investigator also interviewed the resident's family member (FM) and law enforcement (LE). The investigation included a review of the resident's medical record, the video surveillance footage, and the LE report.

The resident's diagnosis included dementia, spondylosis (an age-related change of the bones and discs of the spine), and pain. The resident's service agreement indicated the resident was dependent on staff for all cares, including medication administration. The resident's medication orders included a narcotic medication used for pain.

Review of the resident's medication orders indicated the resident had an order to receive a narcotic pain medication at 7:30 a.m. and 7:00 p.m. every day. In addition to the scheduled doses, the resident could have the narcotic pain medication every four hours as needed for pain.

Review of the resident's individual narcotic record, a document used to track narcotic counts, indicated the resident's as-needed narcotic pain medication was signed out midafternoon nineteen days in a thirty-eight-day period. Of those nineteen days, twelve days were signed out by the AP. The other seven days indicated a forged signature.

Review of the AP's timecards indicated the AP worked all nineteen days the resident received an as needed narcotic pain medication. The AP's timecards also indicated the AP did not work on the days the resident did not receive an as needed pain medication.

Review of facility video surveillance footage showed the AP walking in the hallway adjacent to the resident's room, looking up and down the other hallways. Next, the surveillance footage showed the AP reaching into her shirt pocket while entering the resident's room. Approximately 40 seconds later, the surveillance footage showed the AP exit the resident's room.

During an interview, an unlicensed personnel (ULP)-C stated one day she was assigned to assist the resident with medications, so she gave the resident her scheduled narcotic in the morning. ULP-C stated she noticed the person working the previous evening had forgotten to sign their name in the narcotic book. ULP-C stated during her lunch break she told ULP-B about the missing signature, and ULP-B said it was probably her because ULP-B had worked the previous evening. ULP-C stated ULP-C and ULP-B went to the resident's room to review the narcotic book immediately following their lunch break. Upon reviewing the narcotic book, ULP-C said she noticed there was a narcotic signed out under her name during the time she was on lunch break, which she never gave the resident.

During an interview, the registered nurse (RN)-F stated the resident had an order to receive a scheduled narcotic for pain two times per day. RN-F stated in addition to the scheduled narcotic, the resident previously had an order for additional doses of the narcotic as needed for pain. RN-F stated the as needed dose of narcotic was discontinued but the medication remained in the resident's locked narcotic box for use of the resident's scheduled dose.

During an interview, the RN-G stated ULP-B and ULP-C had notified the nurse ULP-C's signature was forged in the resident's narcotic book. RN-G stated her and the Licensed Assisted Living Director (LALD) reviewed the resident's narcotic book and noted multiple times the resident's

narcotic book was signed but the medication was not documented in the resident's medical record, and the signatures seemed "suspicious." RN-G stated her and the LALD reviewed video surveillance footage, which showed the AP looking around the halls, putting her hand in her pocket while entering the resident's room, and exiting the resident's room a short time later. RN-G stated the AP was not assigned to the resident and had no reason to be in the resident's room. RN-G stated her and the LALD reviewed the AP's timecards and noted the AP was working every shift the resident's narcotic book was signed for an as needed medication. RN-G stated law enforcement was notified. RN-G stated all staff members were interviewed the day the incident was noted, including the AP. RN-G stated the AP denied the allegations and never returned to the facility.

The AP is no longer employed by the facility.

In conclusion, 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:
(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:
(1) Engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or
(2) Fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.
(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. Unable to be interviewed.
**Family/Responsible Party interviewed**: Yes
**Alleged Perpetrator interviewed**: No. Attempts to interview the AP were unsuccessful.

**Action taken by facility:**

The facility reviewed its policies and procedures regarding vulnerable adult prevention.
The facility provided training for all staff related to vulnerable adult maltreatment.

**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.

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
Lyon County Attorney
Marshall City Attorney
Lyon County Sheriff's Office

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 29446 | A. BUILDING: _____ B. WING _____ | C 12/01/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HERITAGE POINTE SENIOR LIVING | 207 NORTH 4TH STREET MARSHALL, MN 56258 |

| (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<br><br>Initial comments<br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL29446002C / #HL29446001M and #HL29446004C / #HL29446003M<br><br>On December 1, 2021, 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 48 clients receiving services under the provider ' s Assisted Living with Dementia Care license.<br><br>The following correction order is issued/orders are issued for #HL29446002C / #HL29446001M and #HL29446004C / #HL29446003M, tag identification 2360. | 0 000 | Assisted Living Provider 144G.<br><br>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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 02360 | Continued From page 1 | 02360 | | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observations, interviews, and document review, the facility failed to ensure 2 of 2 residents reviewed (R1 and R2) were free from maltreatment. R1 was financially exploited. R2 was neglected.<br><br>Findings include:<br><br>On December 1, 2021, the Minnesota Department of Health (MDH) issued a determination that financial exploitation and abuse occurred, and individual staff persons were 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 | | |