Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL295565244M
Compliance #: HL295568903C

Date Concluded: April 13, 2023

Name, Address, and County of Licensee Investigated:
The Waters of Plymouth
11305 Highway 55
Plymouth, MN 55447
Hennepin County

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

Evaluator's Name:
Jana Wegener, 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 three residents (resident #1, resident #2, and resident #3) when the AP took the residents Morphine (narcotic pain medication) for her own personal use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP is responsible for the maltreatment. The AP was observed on video surveillance taking multiple doses of resident narcotic medications then put them in her pocket. The AP documented administering multiple doses of PRN Morphine to three residents, however, on video surveillance the AP never enter the resident rooms to administer the medication. Several months of resident records indicated the AP documented administering 117 of 120 doses of PRN Morphine to the three residents. The AP was the only staff to ever document administering Morphine to two of the three residents. The resident records lacked indications for administering the PRN Morphine including pain or shortness of breath. The resident record

lacked utilization of PRN Morphine unless the AP worked. A preponderance of evidence indicated financial exploitation by drug diversion likely occurred.
falsely documented administering multiple doses of a controlled narcotic medication Morphine, prescribed as needed (PRN) for pain and shortness of breath to resident's receiving hospice end of life care. The AP then took the medication for her own personal use.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's families. The investigation included review of resident records, progress notes, medication administration records (MAR), narcotic logs, medication administration reports, facility investigation documentation and evidence, and police report. Also, the investigator observed medication administration practices at the facility to prevent diversion of controlled drugs.

Resident #1 resided in an assisted living facility memory care unit with diagnoses including Alzheimer's Disease. The resident record indicated she received hospice end of life care with medication management services and medication administration. The resident's assessment indicated she was cognitively impaired, and unable to make her needs know. The assessment indicated the resident had no nonverbal signs of pain.

The resident's MAR included Morphine Sulfate 2.5 milligrams (mg) solutab, prescribed every hour PRN for pain and shortness of breath.

The resident's MAR, medication passing detail report, and narcotic log from November 16, 2022, to February 6, 2023, indicated the AP documented administering 58 of 61 doses of PRN Morphine to the resident. After the AP's employment ended, the Morphine was not utilized by the resident and was discontinued.

The resident's progress notes lacked documentation of indications for the AP to administer the PRN Morphine to the resident including pain, or shortness of breath.

Resident #2 resided in an assisted living facility with diagnoses including congestive heart failure. The resident record indicated she was recently admitted to hospice for end-of-life care with medication management services and medication administration. The resident's assessment indicated the resident was able to utilize her pendant call light and verbalize her needs.

The resident's MAR included orders for Morphine Sulfate 5 mg solutab, prescribed every hour PRN for pain and shortness of breath.

The resident's MAR, medication passing detail report, and narcotic log indicated the AP documented administering 15 doses of PRN Morphine. The MAR indicated no other staff ever administered the medication to the resident and the Morphine was discontinued.

The resident's progress notes lacked any documentation of pain, or difficulty breathing to indicate the resident's need for 15 doses of Morphine.

During email communication leadership staff verified the resident was able to make her needs known and would ring if she needed PRN pain medication.

A review of the resident's call light logs indicated she did not ring for assistance when the AP documented administering PRN Morphine to the resident.

When interviewed the resident #2 denied having pain.

Resident #3 resided in an assisted living facility with diagnoses including dementia with behavioral disturbances and Alzheimer's Disease. The resident record indicated she received hospice end of life care with medication management services and medication administration. The resident's assessment indicated she was cognitively impaired.

The resident's MAR, included orders for Morphine Sulphate 5 mg solutab, prescribed every hour PRN for pain and shortness of breath.

The resident's MAR, medication detail report, and narcotic log indicated the AP documented administering 44 doses of PRN Morphine to the resident from November 15, 2022, to February 6, 2023. No other staff ever administered Morphine to the resident, and the medication was discontinued.

The resident's progress notes lacked any documentation of difficulty breathing or pain to indicate the residents need for 44 doses of Morphine.

When interviewed the resident's family member stated resident #3 did not have pain or shortness or breath and they were never notified of any changes requiring Morphine. The family member stated although resident #3 was prescribed PRN Morphine when she was admitted to hospice, it was intended to be used if the resident had a change of condition, was actively dying, and required it for comfort.

The facilities narcotic logbook included several pages of PRN Morphine for the three residents. The logbook signatures appeared as if the medication had been signed out by multiple different staff. However, when comparing the narcotic log to the medication passing detail report, and resident's MARs the AP documented administering a total of 117 of 120 PRN Morphine doses to the three residents. The AP was the only staff to ever administer the PRN Morphine to two of the three residents. In addition, there were multiple times the Morphine was signed out in the

logbook, after the medication was documented as administered by the AP. The AP also documented administering the PRN Morphine to resident #1 and resident #3 at the same time despite the resident's being located on two different floors in the facility.

A review of the AP personnel files indicated she was hired, trained to pass medications, and about one month after her first independent medication passing shift, began signing out PRN Morphine to the residents. The number and frequency of PRN Morphine documentation administration by the AP increased until her employment ended.

A facility investigation report indicated the AP was witnessed on video surveillance not entering the resident rooms to administer PRN Morphine as documented.

A police report indicated the facility had concerns when the AP administered PRN Morphine to resident #1 because she was sweaty. The facility investigated the AP's medication administration practices, reviewed medication administration records, and video surveillance. The report indicated the video surveillance identified the AP put controlled drugs into her pocket and never entered the resident's rooms to administer the Morphine as documented.

When interviewed facility leadership stated the AP was witnessed on video entering the narcotic drawer of the medication cart, removed multiple narcotics, placed them in her hand, then opened the top drawer of the medication cart, dropped the narcotics into the top drawer, then later put the narcotics into her pocket. Leadership staff stated the AP was observed standing at the medication cart signing out multiple PRN narcotics in the logbook, but never entered the resident's apartments to administer the Morphine as documented.

The AP denied taking the resident's Morphine for her own personal use. The AP had no explanation why she was not seen on video surveillance enter the resident's rooms to administer the PRN morphine as documented.

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:
(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: R2, yes. R1 and R3 were unable to be interviewed.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility identified potential drug diversion, investigated, and reported to Minnesota Adult Abuse Protection (MAARC), and law enforcement. The facility now audits PRN narcotic medication administration for patterns of potential diversion. The facility implemented a new process for unlicensed personnel to notify a nurse if a PRN controlled medication is needed, and the nurse must assess the resident prior to authorizing the medication to be administered. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
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 651-201-4890 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
Plymouth City Attorney
Plymouth Police Department
Drug Enforcement Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29556	A. BUILDING: _____ B. WING _____	C 03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF PLYMOUTH	11305 HIGHWAY 55 PLYMOUTH, MN 55441

(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****** HOME CARE PROVIDER/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: #HL295565244M, and #HL295568903C On March 20, 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 88 residents receiving services under the provider ' s Assisted Living with Dementia Care license. The following correction order is issued/orders are issued that were not issued at the time of immediate correction orders. The following correction order is issued/orders are issued for #HL295565244M, and #HL295568903C, tag identification 2360.	0 000	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29556	A. BUILDING: _____ B. WING _____	C 03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF PLYMOUTH	11305 HIGHWAY 55 PLYMOUTH, MN 55441

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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: The facility failed to ensure three of three resident reviewed (R1, R2, and R3) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual staff person was responsible for the maltreatment of R1, R2, and R3, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	