DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304154762M
Compliance #: HL304156226C

Date Concluded: October 24, 2024

Name, Address, and County of Licensee Investigated:
New Perspective Waconia
500 Cherry St,
Waconia, MN 55387
Carver County

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

Evaluator's Name: Brandon Martfeld, RN BSN
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):
A facility unlicensed staff member, alleged perpetrator (AP), financially exploited six residents, resident #1, resident #2, resident #3, resident #4, resident #5, and resident #6, when the AP took narcotic medication from the six residents for personal use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP financially exploited resident #1, resident #2, resident #3, resident #4, and resident #5. There was a pattern of increased dispensing of Oxycodone (opioid narcotic) to resident #1, resident #2, resident #3, resident #4, and resident #5 by the AP during the night shift when the AP worked. In addition, resident #1, resident #3 and resident #4 denied receiving any Oxycodone at night. It could not be determined if the AP financially exploited resident #6.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and family members of the residents. The investigation included review of the resident records, facility internal investigation, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

Resident #1 resided in an assisted living facility. Resident #1's diagnoses included low back pain and chronic pain. Resident #1's service plan included assistance with medication administration. Resident #1's provider order included Oxycodone (opioid narcotic) 5 milligram (mg) one tablet twice daily as needed for pain.

Resident #2 resided in an assisted living memory care unit. Resident #2's diagnoses included dementia and pain. Resident #2's service plan included assistance with medication administration. Resident #2's provider order included Oxycodone 5mg, ½ tablet every 12 hours as needed for pain.

Resident #3 resided in an assisted living facility. Resident #3's diagnoses included mild cognitive impairment, hip, and low back pain. Resident #3's service plan included assistance with medication administration. Resident #3's provider order included Oxycodone 5mg, ½ tablet twice daily as needed for pain.

Resident #4 resided in an assisted living facility. Resident #4's diagnoses included osteoarthritis and pain. Resident 4's service plan included assistance with medication administration. Resident #4's provider order included Oxycodone 5mg, one tablet every six hours as needed for severe pain.

Resident #5 resided in an assisted living memory care unit. Resident #5's diagnoses included Alzheimer's disease, pain in the right shoulder, low back, and right leg. Resident #5's service plan included assistance with medication administration. Resident #5's provider order included Oxycodone 5mg, 1 tablet three times a day and every three hours as needed for pain.

Resident #1's medication administration records were reviewed for two months during the time frame the AP was employed and dispensing medications at the facility. During the first month, resident #1 received two doses of as needed Oxycodone and none were administered during an overnight shift. The second month, when the AP was dispensing medications, resident #1 received 10 doses of as needed Oxycodone. The AP gave resident #1 four of the 10 doses of the Oxycodone during the overnight shift. Except for the AP, resident #1 did not request or require an Oxycodone during an overnight shift.

Resident #2's medication administration records were reviewed for two months during the time frame the AP was dispensing medications at the facility. During the first month, resident #2 received one dose of as needed Oxycodone, none from the AP. The second month, resident #2 received eight doses of as needed Oxycodone. The AP gave seven of the eight doses of the

Oxycodone on the overnight shift. The other dose given to resident #2 was not given on the overnight shift.

Resident #3's medication administration records were reviewed for two months during the time frame the AP was employed and dispensed medications at the facility. The first month, resident #3 received six doses of as needed Oxycodone. That month, the AP gave one of the two doses of Oxycodone to resident #3 on the overnight shift. The second month, resident #3 received 12 doses of as needed Oxycodone. The AP gave eight of the 12 doses Oxycodone to resident #3 on the overnight shift. The second month, the AP was the only staff to administer Oxycodone to resident #3 during the overnight shift.

Resident #4's medication administration records were reviewed for two months during the timeframe the AP was employed and dispensed medications at the facility. The first month, resident #4 received six doses of as needed Oxycodone. The AP gave resident #4, four of the six doses of as needed Oxycodone during an overnight shift. During the second month, resident #4 received 16 doses of as needed Oxycodone. The AP gave 12 of the 16 doses to resident #4 during the second month on the overnight shift. The AP was the only staff to dispense oxycodone to resident #4 during the overnight shift.

Resident #5's medication administration records were reviewed for two months during the timeframe the AP was employed and dispensed medications at the facility. The first month, resident #5 received two doses of as needed Oxycodone. The AP gave both doses of Oxycodone during an overnight shift. The second month, the AP gave resident #5, 15 of the 15 doses of Oxycodone during an overnight shift. The following month, when the AP was no longer employed by the facility, resident #5 did not receive any as needed Oxycodone.

The facility investigation indicated there was an increase in administered as needed Oxycodone to several residents by the AP in a 12-day period the AP dispensed medications at the facility. The AP was the only staff providing medication administration during the night shift and the only staff with access to the key to the locked narcotic medications. During the investigation, Resident #1 and resident #3 who were able to be interviewed, stated they had not requested Oxycodone for the dates in question. The facility reviewed call light logs which confirmed the residents did not use their call lights to request Oxycodone. The investigation identified the AP consistently documented giving residents Oxycodone on the overnight shift and more than other staff. In addition, care staff working in the memory care stated only resident #6 required as needed Oxycodone medication, not resident #2 and resident #5 who also resided in the memory care unit.

During an interview, resident #1 stated she used as needed Oxycodone on the days she showered because of her back pain. She never requested or took Oxycodone at night. Resident #1 stated her pain had not increased in the last two months.

During an interview, resident #3 stated she usually used the Oxycodone medication during the day. Resident #3 could not recall when she last used Oxycodone medication at night. Resident #3 stated she did not frequently use the as needed Oxycodone medication.

During an interview, resident #4 stated she had Oxycodone for pain but did not like taking it because it made her sick to her stomach. Resident #4 stated she did not need Oxycodone during the night for pain.

During an interview, unlicensed staff member stated she noticed a couple of things that were unusual working a shift after the AP's shift. First resident #2 and resident #5 received as needed Oxycodone one night documented by the AP for the exact same time. It was not common for resident #2 and resident #5 to request Oxycodone in the middle of the night. The unlicensed staff stated the AP started her shift walking with a limp because she hurt her knee but when the unlicensed staff member returned the following morning, the AP was talking and walking fast without a limp. Unlicensed staff member stated she reported her concerns to facility leadership.

During an interview, facility leadership stated an unlicensed staff member reported the AP frequently gave as needed pain medications. Leadership stated they reviewed the as needed pain medication and found the AP gave more as needed pain medication, specifically Oxycodone than any other staff member. Leadership stated an unlicensed staff member working in the memory care unit was interviewed during the dates in question and the unlicensed staff member stated the residents in memory care did not have increase restlessness or pain. Leadership stated resident #1 and resident #3 were interviewed and both residents stated they did not request Oxycodone from the AP during the dates in question. Leadership stated law enforcement was notified and the AP was suspended during the investigation.

During an interview, the AP stated she was wrongfully accused by the facility. The AP denied taking Oxycodone from resident #1, resident #2, resident #3, resident #4, and resident #5 for personal use.

The law enforcement report indicated the investigation was closed pending further information.

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, all residents interviewed.
Family/Responsible Party interviewed: Yes, except no family member reached for resident #2.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility notified the families of the residents involved in the financial exploitation. The AP is no longer employed by 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
Carver County Attorney
Waconia City Attorney
Carver County Police Department
Drug Enforcement Administration

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30415	A. BUILDING: ______ B. WING ______	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - WACONIA	**500 CHERRY STREET WACONIA, MN 55387**

(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: # HL304154762M/#HL304156226C On October 1, 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 115 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for# HL304154762M/#HL304156226C, 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		

Minnesota Department of Health

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	30415	A. BUILDING: ________ B. WING ________	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - WACONIA	**500 CHERRY STREET WACONIA, MN 55387**

(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
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 one of one residents 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	No plan of correction required.	