Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304843285M
Compliance #: HL304843443C

Date Concluded: August 6, 2024

Name, Address, and County of Licensee Investigated:
Midwest Care Facilities
DBA Autum Hills Assisted Living
2528 Park Avenue NW
Bemidji, MN 56601
Beltrami County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Inconclusive

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), an unlicensed personnel (ULP), financially exploited a resident when she took a narcotic pain medication for personal use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was inconclusive. Due to incomplete and conflicting accounts of the incident, it could not be determined if maltreatment occurred. The facility failed to investigate the allegations at the time they were identified, and the AP denied taking medications from a resident for her own personal use.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, incident reports, personnel files, staff schedules, and related policies and procedures. Also, the investigator observed medication administration in the facility.

The resident resided in an assisted living facility. The resident's diagnoses included dementia and history of left hip fracture. The resident's service plan included assistance with dressing, grooming, bathing, mobility, and medication administration. The resident's assessment indicated facility staff were responsible for managing and administering the resident's medications. The resident had leg pain which was controlled by scheduled narcotic pain medications.

Facility documentation indicated the AP was observed taking the resident's narcotic pain medication out of the locked medication cart and putting it into a medication cup. The AP then walked back to the medication room a few minutes later and did not enter the resident's room. The AP documented that she administered the pain medication.

The resident's medication administration record (MAR) indicated the AP administered the narcotic pain medication on the date of the alleged incident. A review of five months of pill count records for narcotic medications indicated there were 39 instances of discrepancies in the count of the resident's narcotic pain medication. The AP was responsible for 22 of the errors, seven errors were attributed to taking medication out of the wrong card, and seven employees were responsible for the remaining ten errors. The resident's record lacked documentation of how the discrepancies were resolved or investigated. The facility could not provide documentation related to the internal investigations into the initial allegation of the AP taking the resident's narcotic pain medication for her own personal use.

During an interview, a facility unlicensed personnel (ULP) stated she watched the AP pop out the resident's narcotic medication, put it in a cup, and walk in the opposite direction of the resident's room. The AP came back to the medication room a few minutes later without the cup, refilled her water, and did not return to the resident's room. The ULP stated the AP was their manager, so they did not address the AP at the time of the incident but reported the incident to facility management. The ULP stated there was a camera in the medication room and a camera in the hallway by the resident's room, so they thought management would be able to determine what happened and if the AP ever went into the resident's room. The ULP stated administration rarely came to the building and was not involved in much related to the onsite operations of the facility but still assumed administration investigated the incident and reviewed camera footage.

During investigative interviews, nursing staff stated there was a frequent pattern with discrepancies in the narcotic count when the AP worked on the medication cart. One nurse was told by a staff member that they observed the AP set-up the resident's narcotic pain medication, but the AP never brought the medication to the resident. The nurse reported the concern to administration who stated that they would investigate the allegation. Nursing staff stated as soon as the AP was removed from working on the medication cart, the number of discrepancies of narcotics "went to almost none."

During an interview, administration stated after they were informed of the allegation, they reviewed narcotic counts and noticed a pattern with narcotic counts being off when the AP passed medication, so the AP was removed from working on the medication cart. Administration stated that they “dropped the ball” on the investigation and confirmed the AP was never interviewed or asked directly if she took the resident's narcotic medication and camera footage was not reviewed or saved from the time of the incident.

During an interview, the AP stated she messed up and went to fast when passing medications and was under a lot of stress. The AP denied taking any medication. The AP could not explain why there were so many discrepancies in the count of narcotic medications when she worked on the medication cart.

In conclusion, the Minnesota Department of Health determined financial exploitation was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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 AP was removed from working on the medication cart.

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 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30484	A. BUILDING: _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST CARE FACILITIES DBA AUTUMN HILLS	2528 PARK AVENUE NW BEMIDJI, MN 56601

(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: #HL304843285M/ #HL304843443C On July 3, 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 25 residents receiving services under the provider's Assisted Living with Dementia Care license. The following immediate correction order is issued. Correction orders with a period to correct that are not immediate may be issued at a later date during the investigation. An immediate correction order was issued on July 3, 2024, for #HL304843285M/ #HL304843443C, tag identification 0110. A monitoring visit was completed on July 30, 2024 to follow up on the immediate correction order identified on July 3, 2024, for #HL304843285M/ #HL304843443C. No action had been taken and	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.	

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0 000	Continued From page 1 non-compliance remained. The following correction orders are issued that were not issued at the time of immediate correction orders for #HL304843285M/ #HL304843443C, tag identification 0620, 2320.	0 000		
0 110	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employment of a licensed assisted living director (LALD). This had the potential to affect all 25 residents receiving assisted living services. This resulted in an immediate correction order issued on July 3, 2024. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 3, 2024, at 9:10 a.m., registered nurse (RN)-B stated the	0 110		

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0 110	Continued From page 2 assisted living director for the facility was usually onsite about two and a half days per month and otherwise lived in the twin cities. RN-B stated assisted living director (ALD)-A oversaw another assisted living location and a home care agency as well. On July 3, 2024, at 9:30 a.m., the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website was reviewed for verification of the licensed assisted living director's licensure. ALD-A was listed as having a residency permit for the licensee that expired on April 24, 2024. On July 3, 2024, at 10:15 a.m., ALD-A stated he was just waiting for his assisted living director license to arrive since he passed his test on June 8, 2024, and recently sent in his transcripts. ALD-A was told his permit expired in April, before he took his test. ALD-A stated he thought he could get an extension since his test was scheduled for later but didn't know if he was supposed to do anything to get an extension on his residency permit. The licensee lacked a LALD to manage and supervise assisted living services for the 25 residents who received assisted living services. An immediate correction order was issued on July 3, 2024 as the licensee did not employ a licensed assisted living director. On July 30, 2024, a monitoring visit was completed to follow-up on the immediate order issued on July 3, 2024. On July 30, 2024, at 3:40 p.m, the Minnesota Board of Executives for Long-Term Services and	0 110		

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0 110	Continued From page 3 Support (BELTSS) website was reviewed for verification of the licensed assisted living director's licensure. ALD-A was listed as having a residency permit for the licensee that expired on April 24, 2024. On July 30, 2024, at 3:45 p.m., clinical nurse supervisor (CNS)-B confirmed there was no LALD at the facility but a licensed practical nurse was working on obtaining her residency permit. On July 30, 2024, at 4:00 p.m., assisted living director (ALD)-A confirmed there was no LALD affiliated with the facility at this time. ALD-A stated that he was working on completing his application to obtain his license and he planned on taking the licensing exam once BELTSS replied to him. ALD-A stated another employee agreed to work on obtaining a residency permit and had submitted an application on July 30, 2024, to obtain her assisted living director in residency permit. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 110		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is:	0 620		

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0 620	Continued From page 4 (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572,	0 620		

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0 620	Continued From page 5 subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) after financial exploitation via narcotic diversion was alleged for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included dementia, history of left hip fracture, and osteoporosis. R1's service plan dated February 8, 2024, indicated the resident received assistance with dressing, grooming, bathing, mobility, and medication administration. R1's most recent assessment dated May 13, 2024, indicated facility staff were responsible for	0 620		

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0 620	Continued From page 6 managing and administering the resident's medications. The resident had leg pain which was controlled by scheduled pain medication and narcotic pain medications. The complaint document indicated on March 24, 2024, at 1:44 p.m., unlicensed personnel (ULP)-C took R1's narcotic medication out of the narcotic box and placed it into a medication cup. The medication was marked as administered, but was never given to R1. The incident was reported to facility management. R1's medication administration record (MAR) for March 24, 2024, indicated ULP-C administered R1's scheduled 2:00 p.m. hydrocodone/APAP 5 mg-325 mg (an opioid pain medication). R1's record lacked any medication error reports for any of the pill count discrepancies or the March 24, 2024, allegation. The facility did not have any documentation related to internal investigations related to the correlation of narcotic counts being off or the allegation against ULP-C. The licensee failed to report the suspected financial exploitation to MAARC. On July 9, 2024, at 9:45 a.m., assisted living director (ALD)-A confirmed the event would be considered reportable and he or the clinical nurse supervisor should have filed a report. ALD-A stated he wasn't sure why it didn't get reported. The licensee's policy addressed vulnerable adult reporting under a home care license, not an assisted living license. The Vulnerable Adults and Maltreatment- Communication, Prevention, and Reporting policy dated July 30, 2021, indicated all staff were mandated reporters. The policy indicated "all home care staff are provided	0 620		

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0 620	Continued From page 7 training regarding the home care bill of rights and reporting requirements under the MN Vulnerable Adults Act during initial orientation and on an annual basis." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards when staff became aware of concerns with discrepencies in the count of narcotic medications and failed to investigate an allegation of financial exploitation via drug diversion for one of one resident (R1) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	02320		

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02320	Continued From page 8 of the residents). The findings include: R1's diagnoses included dementia, history of left hip fracture, and osteoporosis. R1's service plan dated February 8, 2024, indicated the resident received assistance with dressing, grooming, bathing, mobility, and medication administration. R1's most recent assessment dated May 13, 2024, indicated facility staff were responsible for managing and administering the resident's medications. The resident had leg pain which was controlled by scheduled pain medication and narcotic pain medications. R1's record contained a Pill Count History report for R1's Hydrocodone/APAP 5 mg-325 mg (an opioid pain medication) tablet which covered February 1, 2024, through July 3, 2024. 39 instances of the narcotic count being off were recorded. 22 of the errors were attributed to ULP-C. Seven of the errors were related to staff taking medication out of the wrong card. Seven employees were responsible for the other ten discrepancies. ULP-C was hired May 11, 2020, to provide direct care and services, including medication administration, to residents at the assisted living facility. The complaint document indicated on March 24, 2024, at 1:44 p.m., ULP-C took R1's narcotic medication out of the narcotic box and placed it into a medication cup. The medication was marked as administered, but was never given to	02320		

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02320	Continued From page 9 R1. The incident was reported to facility management. R1's medication administration record (MAR) for March 24, 2024, indicated ULP-C signed that they administered R1's scheduled 2:00 p.m. hydrocodone/APAP 5 mg-325 mg. R1's record lacked medication error reports for any of the pill count discrepancies or the March 24, 2024, allegation. The facility did not have any documentation related to internal investigations related to the correlation of narcotic counts being off or the allegation against ULP-C. There was no documentation to support that adminisration reviewed or evaluated their systems to ensure proper storage and control of narcotic medication. On July 3, 2024, at 10:45 a.m., registered nurse (RN)-B stated she was told that ULP-C had taken R1's medications out but never went to R1's room and instead went in the opposite direction and never went down to R1's room. RN-B stated she did not interview ULP-C about the allegation but reported it to assisted living director (ALD)-A as he was the one who would handle investigations. RN-B stated she told ALD-A there was video and he needed to watch it because they felt she had taken R1's oxycontin and ALD-A had told her "If three people are suspicious, I don't need to watch the video so at that point, he said he was going to take care of the situation and discuss it with her." RN-B stated she had started at the facility a few months ago and she immediately noticed the narcotic count was always off and there was not a good system for tracking liquid narcotics. RN-B stated after ULP-C was removed from administering medications, they saw a significant decrease in discrepancies in narcotic counts. RN-B stated it was not their decision to retain	02320		

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02320	Continued From page 10 ULP-C as an employee and she had concerns with her approach with residents and families and reported these concersn to ALD-A. On July 3, 2024, at 11:35 a.m., facility nurse (FN)-D stated whenever there was a 2 p.m. medication due to be given, ULP-C would take it from the person working the cart and say she'd administer it and the narcotic counts were usually off when ULP-C was working on the cart and administering medications. When the count was off, ULP-C wouldn't even come look [at the discrepancy], she just kept saying, "it's fine just put the number down". That happened on multiple occasions. FN-D stated after several times, she and the other facility nurse told assisted living director (ALD)-A that ULP-C could not administer medications. FN-D stated they decided to count gabapentin medication because they had a resident that was on it four times a day and someone would go to give a noon or 4:00 p.m. dose and it had already been punched out so they questioned if the resident was really getting her gabapentin or is someone taking it. FN-D stated that random [medication] cards with random days or times were popped out with no rhyme or reason. As soon as gabapentin was counted as a controlled substance, there were no more problems with missing gabapentin. As soon as we took medication administration rights away from [ULP-C], pill count discrepancies went to almost none. FN-D was asked why ULP-C remained employed after allegations of drug diversion and stated "That's a great question that I have been asking since we found this diversion going on. She was made housing manager...it's very sad, I'm not sure why she still has a job. [ALD-A] has the ability to hire and fire, not us." On July 3, 2024, at 11:55 a.m., ULP-C stated she	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30484	A. BUILDING: _____ B. WING _____	C 07/03/2024

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02320	Continued From page 11 "messed up" and went "too fast" when passing medications and she had been under a lot of stress. ULP-C denied taking any medications and stated "I probably clicked on the wrong one, I didn't take anything." ULP-C was asked why there were so many discrepancies with narcotic medications that seemed to stop when she was removed from the medication cart. ULP-C stated, "I don't know, I messed up. I know I did not take them. I don't take medicine at all, nothing at all, I just messed up. I'm in a better head now." ULP-C was asked why there would be an allegation that she took narcotics and was asked if she had ever taken a resident's medications for her own use. ULP-C stated, "no and I have no idea why a spotlight is on me. No idea, maybe someone doesn't like my hyperactivity. I just like to have fun at work and the residents like it." On July 8, 2024, at 11:00 a.m., ULP-E stated she watched ULP-C pop out a narcotic medication, put it in a cup, and go in the opposite direction of the resident's room. ULP-C came back to the medication room a few minutes later without the cup, refilled her water, and did not go back to the resident's room. ULP-E stated ULP-C was their manager so she didn't want to address it directly with her at that time but since there was a camera in the medroom and a camera in the hallway by the resident's room, management should have been able to determine what happened and if ULP-C ever went into the room. ULP-E stated assisted living director (ALD)-A rarely came on site and was only at the facility about two days per month and was not involved in much for operations on site. ULP-E stated she didn't feel like ULP-C ever passed medications correctly or followed the appropriate steps. ULP-E stated she assumed ALD-A would have investigated the incident and reviewed the camera footage.	02320		

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02320	Continued From page 12 On July 9, 2024, at 9:45 a.m., assisted living director (ALD)-A stated after the allegation came up, they looked at the history of narcotic counts being off when ULP-C was working and the new allegation and "that attributed to the decision to pull [ULP-C] off of meds." ALD-A confirmed he never interviewed ULP-C or asked her directly if she had taken a resident's narcotics for her own personal use. ALD-A stated he should have interviewed ULP-C and should have asked her directly about the allegations and did not know why he failed to do so. ALD-A stated that ULP-C was a long term and valued employee and she learned a valuable lesson. ALD-A stated that he "dropped the ball" on the internal investigation and saw where he need to "pick it up" going forward. ALD-A acknowledged there was not a review of the narcotic storage or administration process despite nursing staff's report of concerns with discrepencies in the narcotic counts and no medication error reports were completed related to narcotic medication. ALD-A also confirmed they were aware of nursing's concern with ULP-C and potential drug diversion related to the narcotic discrepencies but did not remove ULP-C from medication administration until learning of this allegation. The licensee's Medication Errors policy dated December 14, 2021, lacked details on how drug diversion would be identified and investigated. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		