Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305373342M
Compliance #: HL305373456C

Date Concluded: July 16, 2024

Name, Address, and County of Licensee Investigated:
Riverside Assisted Living
812 East Centre Street
Royalton, MN 56373
Morrison County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, 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 the resident when she removed an extra dose of the resident's controlled medication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. Video surveillance showed the AP remove an extra tablet of Tramadol (a pain-relieving medication) and placed it in the pocket of her uniform top. The resident's medication order stated one Tramadol tablet every six hours. The AP removed two tablets from the medication card, crushed one of the tablets in the medication crushing device and placed the second tablet in her pocket.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted a family member. The investigation included

review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included stroke and chronic pain syndrome. The resident's service plan included assistance with medication management and behavior management. The resident's assessment indicated the resident had frequent to constant pain and required occasional assistance with her wheelchair.

During shift change at the end of the AP's shift, and the beginning of unlicensed personnel (ULP)-2's shift, the AP and ULP-2 completed shift to shift count of the controlled medications. The count showed there was a tablet of Tramadol missing. The AP and ULP-2 searched the medication cart for the missing tablet without success. The AP and ULP-2 reported the missing tablet to the after-hours nurse. The after-hours nurse directed the AP and ULP-2 to document a note and notify the facility nursing staff. The AP went home at the end of her shift and ULP-2 proceeded with his shift and responsibility of the medication cart.

The facility internal investigation included a statement from a licensed practical nurse (LPN) that indicated she received notification via text message there was a missing Tramadol tablet. The following day, the LPN was not initially able to determine an explanation of the missing medication, until reviewing video surveillance. Video surveillance footage showed the AP removed two tablets of Tramadol from the medication card to a medication cup. The AP took one tablet and placed it in a pill crush sleeve and began to crush the medication. The AP then placed the medication cup containing the second tablet in the pocket of her scrub top and walked away from the medication cart. The medication cup was no longer in the AP's hand when removed from her pocket.

The law enforcement report indicated the officer witnessed surveillance video of the AP placing her hand with the tablet in her pocket, and nothing was in the AP's hand when removed from her pocket. The officer was unable to contact the AP when visiting her residence.

During an interview, ULP-1 stated there had not been any concerns or missing medications until shortly after the AP began working at the facility. ULP-1 stated she thought the AP could have taken the medication, as the AP had previously had a knee surgery.

During an interview, ULP-2 stated he performed the medication count with the AP when a Tramadol tablet was missing. ULP-2 stated the AP appeared confused as to what could have happened to the missing tablet. ULP-2 stated there had not previously been instances where medication was missing. ULP-2 stated it was unacceptable for a staff member to place medication in their pocket.

During an interview, an administrative staff member stated the AP had not been employed by the facility for very long before the medication went missing. The staff member stated there was a camera that directly observed the medication cart, and she watched the AP place the

medication in her pocket on the surveillance video. The staff member stated when she suspended the AP pending investigation, she did not dispute the allegation or ask any questions.

During an interview, a family member stated she has not had any concerns at the facility and felt the resident was safe at the facility. The family member stated the resident liked the facility.

During an interview, the resident stated a family member notified her that staff had taken her medication. The resident stated she was having more pain, and her pain has lessened since the AP was no longer employed at the facility.

During an interview, the AP stated the day of the incident the controlled medication count was correct when she took the medication cart keys at the start of her shift and there was one tablet of Tramadol missing at the end of her shift. The AP denied taking the Tramadol tablet and stated she did not know what happened to it. The AP stated the resident took her medication in a crushed form, and she did not know why she took two tablets out of the medication card. The AP stated she did not recall placing a tablet in her pocket.

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;

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):
(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated the incident. 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
Morrison County Attorney
Royalton City Attorney
Royalton Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30537	A. BUILDING: _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE ASSISTED LIVING	812 CENTRE STREET EAST ROYALTON, MN 56373

(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: #HL305373456C /#HL305373342M #HL305379622C /#HL305371820M On May 30, 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 12 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL305373456C/#HL305373342M, tag identification 2360. No correction orders are issued for #HL305379622C /#HL305371820M .	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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RIVERSIDE ASSISTED LIVING	812 CENTRE STREET EAST ROYALTON, MN 56373

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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 one of one resident(s) 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 is required for this tag.	