Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305463583M
Compliance #: HL305465915C

Date Concluded: January 11, 2023

Name, Address, and County of Licensee Investigated:

Elk Ridge Assisted Living
821 7th Ave SW
Perham, MN 56573
Ottertail County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Jana Wegener, 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.

Initial Investigation Allegation(s):
The alleged perpetrator (AP)1 financially exploited a resident by drug diversion when the resident's Tramadol (a narcotic pain medication) was taken by the AP for her own personal use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. Based on a preponderance of evidence, AP1 was responsible for the maltreatment. AP1 was responsible for the resident's medication management including consultation and changes from the medical providers. AP1 contacted the resident physician and requested the resident's Tramadol be scheduled for pain. AP1 documented the resident refused the medication and the Tramadol was destroyed. However, the resident record lacked documentation the Tramadol was ever entered on the resident's medication administration record for staff to administer. The

AP was unable to provide any documentation for the administration, disposition, or destruction of the Tramadol. As a result, 840 tablets of the resident's Tramadol were unaccounted for.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, the resident's pharmacy, and family. The investigation included a review of the resident medical record, narcotic counts, facility policy and procedures, and employee records. The investigator observed the facilities electronic controlled drug counting system, medication administration system, and destruction of medications.

The resident resided in an assisted living facility with diagnoses including stroke, aphasia (difficulty speaking), and Diabetes Mellitus. The residents medical record indicated the resident received medication services including ordering, medication set up, and administration five times daily. AP1 was responsible for medication consultation and changes from the medical providers and indicated a licensed nurse would reorder medications and secure them in locked storage with measures in place to prevent diversion.

The resident's assessment, completed by AP1, indicated the resident was oriented, able to make her needs known, and made her own decisions. The assessment indicated AP1 was responsible to manage the resident's medications, and the resident had no reported pain.

The resident's progress notes indicated AP1 documented calling the resident's provider and requested the resident's Tramadol order to be changed and scheduled, indicating the medication was already prescribed as needed. The note indicated the resident's provider ordered the Tramadol to be scheduled four times daily. The note indicated the Tramadol was delivered, but the resident refused to take the medication. The next day AP1 documented she spoke to the resident who declined trying the Tramadol. Approximately a week later, AP1 documented in the resident's progress notes the resident continued to decline Tramadol, and AP1 destroyed the Tramadol.

When interviewed the pharmacy staff stated the resident received a total of 12 refills of Tramadol. The pharmacy staff indicated the resident's last Tramadol prescription was changed and scheduled four times daily with 180 tablets filled for the resident. The pharmacy staff stated one day a nurse from the facility called and questioned the residents Tramadol order. The nurse stated the resident had never received Tramadol and the medication was not listed on the resident's medication administration record for administration.

The pharmacy provided Monthly Audit Log included documentation the facility received 12 refills of Tramadol, with a total of 840 tablets received.

The facility provided Pill Count History report indicated the residents Tramadol was not administered or counted and failed to include any documentation the resident was prescribed Tramadol.

A nurse stated one day the resident was complaining of dental pain and AP1 instructed the nurse to update the residents Neurontin (used for pain) order. The nurse reviewed the resident's physician orders and saw a physician order included a scheduled dosage increase of the residents Tramadol, but the resident was never on Tramadol, and the medication was not listed on the resident's medication administration record. The nurse stated there was no documentation the resident had ever received Tramadol. The nurse indicated she called the pharmacy to question the order and was told the residents Tramadol was delivered. The nurse stated she was not able to locate any Tramadol for the resident and there was no documentation the Tramadol had ever been received by the facility.

When interviewed several unlicensed personnel stated narcotic counts were completed during shift change. None of the unlicensed staff recall seeing Tramadol on the resident's medication administration record, nor do they remember counting any Tramadol for the resident during narcotic counts.

When interviewed AP1 denied taking the residents Tramadol for her own use. AP1 stated the resident had not received Tramadol for "some time". AP1 stated if a resident was not taking a medication, and it was not listed on their medication administration record, she could potentially still continue to reorder it because that was how she did it in the previous electronic medical record system.

The facility was unable to provide documentation for accountability of the residents 840 Tramadol tablets including counting/tracking, administration, and destruction of the medication.

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:
(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.
Family/Responsible Party interviewed: Yes
A**lleged Perpetrator interviewed**: Yes

Action taken by facility:
The facility updated the medication management of controlled medications to prevent diversion and educated staff.

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
Ottertail County Attorney
Perham City Attorney
Perham Police Department
Minnesota Board of Nursing
Minnesota Board of Pharmacy
Drug Enforcement Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30546	A. BUILDING: _____ B. WING _____	C 12/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELK RIDGE ASSISTED LIVING SC	821 7TH AVENUE SW PERHAM, MN 56573

(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 Initial comments ******ATTENTION****** 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: #HL305463583M/#HL305465915C On November 29, 2022, 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 5 residents receiving services under the provider's Assisted Living license. The following immediate correction orders were issued for HL305463583M/HL305465915C, tag identification 1690. The immediacy was removed on December 22, 2022, for tag 1690. Non-compliance remained at a scope and severity of a F for tag 1690. The following correction orders which are not immediate were issued for	0 000	The Minnesota Department of Health documents 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	

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0 000	Continued From page 1 HL305463583M/HL305465915C, tag identification 0720, and 2360.	0 000		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Minnesota Department of Health (MDH) surveyor had access to records in a timely manner in order to complete maltreatment investigations into potential drug diversion. The licensee was unable to provide requested records for two of two residents, (R1 and R3) reviewed for narcotic diversion. 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). Findings include: R2 was admitted to the facility on June 18, 2021, with diagnoses including stroke and Diabetes	0 720		

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0 720	Continued From page 2 Mellitus. R2's service plan addendum effective September 9, 2022, indicated R2 received medication management services five times daily. The service plan indicated the licensed nurse would reorder medications and secure them in locked storage in a centralized location with measures in place to prevent diversion. During interview on December 7, 2022, at 12:59 p.m. Pharmacy Director (PD)-F stated R2 was prescribed Tramadol from January, 2022, through November 3, 2022, and during that time the facility received 12 refills, for a total of 840 Tramadol tablets. PD-F stated R2 was prescribed Tramadol four times daily as needed, and had Tramadol prescription refilled regularly with the last refill prescription number 14011627, for 180 Tramadol 50 mg tablets, filled on October 10, 2022, when the Tramadol order was changed from PRN to being scheduled four times daily for administration. R2's medication administration record (MAR) for June 2022, to November 2022, contained no documentation regarding the Tramadol including administration. Additional medical records, tracking of the controlled drug including shift to shift counts, and disposition of the Tramadol narcotic medication was requested, and none was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 720		

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01690	Continued From page 3	01690		
01690 SS=I	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the	01690	Minnesota Department of Health is documenting the State Licensing	

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01690	Continued From page 4 accountability of controlled substances for one of one resident (R2), reviewed with missing narcotic medication. R2 was missing approximately 840 Tramadol tablets (a controlled narcotic pain medication) which were provided to the facility by the pharmacy. The facility had no record R2 receiving any of the 840 Tramadol. The facility lacked policies and procedures regarding resident medication management which were developed under the supervision and direction of a registered nurse (RN), licensed health professional, or pharmacist consistent with current practice standards. Because of the facilities lack of systems to prevent narcotic diversion, this had the potential to affect all residents who are or will be prescribed narcotic medication. This resulted in an immediate correction order on December 7, 2022. The immediacy was removed on December 22, 2022, when the facility revised the medication policy and trained staff on updated procedures. Non-compliance remained at a scope and severity of a F. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: R2 was admitted to the facility on June 18, 2021,	01690	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.	

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01690	Continued From page 5 with diagnoses including stroke and Diabetes Mellitus. R2's service plan addendum effective September 9, 2022, indicated R2 received medication management services five times daily. The service plan indicated the licensed nurse would reorder medications and secure them in locked storage in a centralized location with measures in place to prevent diversion. R2's assessment dated December 2, 2022, indicated the resident was oriented, able to make herself understood, and made her own decisions. The assessment indicated R2 had no reported pain. R2's Care plan dated November 30, 2022, indicated the resident required medication set up and administration, and medication monitoring and documentation would be done per policy. A pharmacy provided delivery tracking sheet indicated RN-A received and signed for R2's Tramadol 50 mg tablets. The pharmacy tracking indicated 90 tablets of Tramadol for R2 were delivered to the facility on August 4, 2022, and September 29, 2022. Although the pharmacy delivered Tramadol to the facility and it was signed as received by RN-A, there was no facility documentation indicating R2 received the Tramadol, nor is there any documentation the Tramadol was logged in for tracking at the facility. R2's medication administration record (MAR) for June 2022, to November 2022, contained no documentation regarding the Tramadol including administration, tracking of the controlled drug including shift to shift counts, and disposition of the Tramadol narcotic medication was requested,	01690		

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01690	Continued From page 6 none was received. R2's progress note dated October 10, 2022, at 12:21 p.m. indicated registered nurse (RN)-A called R2's provider to request Tramadol be changed from PRN (as needed), to scheduled, which indicated the medication was already prescribed as needed. The note indicated R2's provider ordered the Tramadol (no documentation of dosage and times) to be scheduled for administration and increased the residents Neurontin dosage. The note indicated the medication was delivered to the facility, but the resident refused the medication. R2's progress note dated October 11, 2022, at 9:03 a.m. indicated RN-A spoke to R2 and asked if she wanted to try the Tramadol for pain relief, but the note indicated the resident declined and the increased Neurontin was working for her pain. R2's progress notes dated October 18, 2022, at 3:10 p.m. indicated R2 was doing better and continued to decline Tramadol. R2's progress note dated October 24, 2022, at 4:12 p.m. indicated RN-A documented in a progress note R2 continued to decline the Tramadol, and indicated the medication was removed from the medication cupboard and destroyed. R2's facility provided Pill Count History from September 1, 2022, to December 2, 2022, indicated R2's Tramadol was never administered or accounted for. The pill count information included only Lorazepam 1 mg daily PRN every six hours as needed for agitation. Although the facility received Tramadol for R2, there was no corresponding documentation of receiving,	01690		

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01690	Continued From page 7 administering, and/or disposition of Tramadol for R2. When interviewed on November 29, 2022, at 10:00 a.m. unlicensed personnel (ULP)-E stated the process to receive medications from pharmacy was to place the bag of received medications in the locked cupboard, and RN-A would go through it. ULP-E stated a shift-to-shift count was completed for all controlled medications. ULP-E indicated all staff had access to the cupboard and showed a removable box with a combination dial on it where the controlled medications were stored. ULP-E stated the only narcotic medication counted for R2 was Lorazepam, and she did not recall Tramadol on R2's orders to be counted. During interview on December 1, 2022, at 12:05 p.m. licensed practical nurse (LPN)- C indicated one day R2 was complaining of dental pain and RN-A instructed her to update R2's Neurontin order. LPN-C stated when she reviewed R2's provider order it included orders for a scheduled, dosage increase of Tramadol. LPN-C stated Tramadol was never on R2's MAR for staff to administer, and there was no indication the resident had ever received Tramadol. LPN-C stated she called the pharmacy and was notified the prescription of Tramadol had been delivered to the facility on October 10, 2022. LPN-C stated she could not find the Tramadol at the facility, the Tramadol was not on R2's MAR for administration, and there was no documentation the Tramadol had ever been received by the facility. LPN-C stated she never witnessed destruction of narcotic medications with RN-A. During interview on December 7, 2022, at 12:59 p.m. Pharmacy Director (PD)-F stated R2 was	01690		

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01690	Continued From page 8 prescribed Tramadol from January, 2022, through November 3, 2022, and during that time the facility received 12 refills, which would be a total of 840 Tramadol tablets. PD-F stated R2 was prescribed Tramadol four times daily as needed, and had Tramadol prescription refilled regularly with the last refill prescription number 14011627, for 180 Tramadol 50 mg tablets, filled on October 10, 2022, when the Tramadol order was changed from PRN to being scheduled four times daily for administration. On November 29, 2022, at 12:15 p.m. RN-A stated R2 had not received Tramadol for some time. RN-A stated if a resident was not taking a medication, and it was not listed on the MAR, she would continue to reorder it because that was how she did it in the previous electronic medical record system. RN-A was unable to provide any documentation R2 was administered Tramadol according to the physician orders. The facility policy and procedure titled Medication Storage dated August 1, 2021, indicated when medications are managed by the facility they would be kept securely locked and stored per manufacturer's directions. The policy indicated only authorized staff would have access to stored medications. The procedure indicated medications managed by the facility would be stored to prevent diversion of medications by residents or others who may have access to the medications. The procedure indicated Schedule II Drugs were stored under a double lock system separate from other medications and counted at the beginning and end of every shift. The policy and procedure lacked processes to prevent diversion including logging-controlled drugs into the facility, ensuring accuracy of medication ordered on the resident's MAR, documenting	01690		

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01690	Continued From page 9 medication administration, tracking all controlled drugs with shift to shift counting, and documentation of disposition of medications including witnessed destruction of controlled drugs to prevent diversion. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01690		
02360	144G.91 Subd. 8 Freedom from maltreatment 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. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R2) was 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 R2, 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.	