Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307836705M
Compliance #: HL307832685C

Date Concluded: July 20, 2023

Name, Address, and County of Licensee Investigated:
Cottage Grove White Pine
6950 East Point Douglas Road South
Cottage Grove, MN 55016
Washington County

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

Evaluator's Name:
Katie Germann, 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), a facility nurse, financially exploited three residents (resident #1, resident #2, and resident #3) when the AP took the resident's morphine (narcotic pain medication) and documented the morphine was destroyed without a physician order.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. Based on a preponderance of evidence, the AP is responsible for the maltreatment. The AP took 16 morphine from resident #1, 29 morphine from resident #2, and 30 Morphine from resident #3. The AP had no physician order to discontinue and/or destroy the residents' morphine, and there was no corresponding destruction documentation regarding any of the 75 Morphine the AP took.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of narcotic records, staff

training, resident medical records, staff personnel files, and facility policies and procedures. Also, the investigator observed staff administering medications to residents.

Resident #1's medical record indicated the resident resided in an assisted living memory care unit with diagnoses including Parkinson's disease and cognitive decline. The residents service plan included assistance with medication management and administration. Resident #1's assessment indicated the resident had dementia and was non-communicative. Resident #1 was on hospice care with orders for morphine 5 mg solutab (dissolvable tablet); every 1 hour as needed for pain.

Resident #2 resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease and adult failure to thrive. The resident's service plan included assistance with medication management and administration. The resident's assessment indicated the resident had dementia. Resident #2 was on hospice care with orders for morphine 5 mg solutab; 1 tablet every 6 hours as needed for pain.

Resident #3 resided in an assisted living memory care unit. The resident's diagnoses included major neurocognitive disorder and osteoporosis. The resident's service plan included assistance with medication management and administration. The resident's assessment indicated the resident has cognitive impairments and chronic pain. Resident #3 was on hospice care with orders for morphine 5 mg solutab; 1 tablet every 6 hours as needed for pain or shortness of breath.

According to an outside report, resident #3 requested morphine and staff were unable to locate the medication card. When investigated, it was discovered residents #1, and #2, were also missing their as needed morphine. Residents #1, #2, and #3 were all receiving hospice care. The hospice company denied discontinuing the morphine order. The report indicated the morphine was not discontinued by any physician, and there was no medication destruction form filled out by the nurse indicating the morphine was destroyed; both of which are required when destroying narcotics.

Resident #2's morphine was documented in the narcotic book by the AP and another facility nurse as, "29 tabs destroyed-not being used." The last time resident #2 used morphine was 23 days prior to the date the AP removed it from the medication cart.

Three days later, the AP documented in Resident #3's narcotic book, "30 tabs destroyed per drug buster" (a liquid that destroys medications). A temporary staff signed next to the AP's signature. Resident #3 had not used the morphine in the prior three months.

Five days after the AP documented destroying Resident #3's morphine, the AP documented in Resident #1's narcotic book, "16 tabs destroyed per drug buster." A temporary staff signed next to the AP's signature. Resident #1 had just taken a dose of morphine the day prior to the AP documenting it was destroyed.

The AP's employee and training records indicated the AP notified the facility of her resignation on the same day the first card of morphine was signed out as destroyed without a physician order. The AP's last day of employment was 16 days after the last card of morphine was signed out as destroyed. The AP was trained regarding narcotic medication destruction.

When interviewed the facility nursing administrator stated all narcotic medication destruction required a staff witness to be present. The nurse would get a physician's order to discontinue the medication prior to destroying a resident's medications.

When interviewed a facility nurse stated the AP brought the narcotic book to her and asked her to sign it. The nurse signed the narcotic book and stated she trusted the AP to destroy the narcotic, so she did not actually observe the destruction or the removal of the morphine from the medication cart.

During interview the AP stated she did not remember what happened to the morphine. The AP stated the facility process for destroying narcotics required two staff present to put the destroyed medication in the drug buster and both staff would sign the "book" (meaning the destruction book). The AP stated she could not recall getting a discontinuation order prior taking resident #1, #2, or #3's morphine out of the medication cart.

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: No, due to cognition.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility investigated the incident and filed a vulnerable adult report.

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
Washington County Attorney
Cottage Grove City Attorney
Cottage Grove Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30783	A. BUILDING: _____ B. WING _____	C 07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGE GROVE WHITE PINE II	6950 EAST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016

(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 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: #HL307832685C/#HL307836705M On July 11, 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 43 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL307832685C/#HL307836705M, tag identification 2360.	0 000	The Minnesota Department of Health documents 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 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 and/or Investigators ' 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 state correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys and/or complaint investigations. 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.	

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0 000	Continued From page 1	0 000	THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPY AND LEVEL ISSUED PURSUANT TO THE MINN. STAT. § 144G.31, SUBDIVISION 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 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 residents, (R1, R2, and R3) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual 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 (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	