Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308091642M
Compliance #: HL308093181C

Date Concluded: February 24, 2023

Name, Address, and County of Licensee Investigated:
Prairie Senior Cottages of Isanti
706 6th Avenue Northeast,
Isanti, MN 55040
Isanti County

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

Evaluator's Name: Brandon Martfeld, 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) financially exploited resident 1, resident 2 and resident 3 when the facility's camera revealed the AP taking narcotics in the medication room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. Camera footage showed the AP ingest narcotics and placed narcotics in her pocket.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the family members of the residents involved and law enforcement. The AP did not respond to a subpoena for an interview. The investigation included review of medical records of the residents involved, the AP's personnel file, staff schedules, facility grievances, facility internal investigation, facility

policies and procedures, and law enforcement report. Also, the investigator observed the facility, resident's rooms, common areas, narcotic medication pass and medication rooms.

All three residents resided in an assisted living memory care unit. Resident 1's diagnoses included Alzheimer's disease. Resident 1's service plan included assistance with medication administration and safety checks. Resident 1's assessment indicated severe impaired cognition. Resident 1's medication management assessment indicated the resident was unable to safely store narcotic and the narcotics were double locked in a medication cart accessible to staff assigned to the resident.

Resident 2's diagnoses included poor memory and cognitive impairment. Resident 2's service plan included assistance with medication administration. Resident 2's assessment indicated severe impaired cognition. Resident 2's medication management assessment indicated the resident was unable to safely store narcotic and the narcotics were double locked in a medication cart accessible to staff assigned to the resident. The same assessment indicated there was camera surveillance in the caregiver office and medication room.

Resident 3's diagnoses included anxiety and panic disorder, stroke, and decreased mental function. Resident 3's service plan included assistance with medication administration. Resident 3's assessment indicated resident 3 was oriented to self and family but was confused with anxious behaviors. Resident 3's medication management assessment indicated the resident was unable to safely store narcotic and the narcotics were double locked in a cupboard accessible to staff assigned to the resident.

The facility's internal investigations for resident 1, resident 2 and resident 3 indicated the AP diverted narcotic medications. The camera footage showed the AP took resident 1's Morphine (narcotic) orally. The camera also showed the AP took resident 2's Morphine orally. The camera footage also showed the AP placed resident 2's lorazepam (antianxiety controlled medication) in her pocket. The camera footage showed the AP had taken resident 3's morphine orally. The camera footage also showed the AP had placed resident 3's lorazepam in her pocket.

The law enforcement report indicated leadership told the officer they reviewed the camera and saw the AP took medications orally and had placed medications in a medication cup and concealed the cup with other medications cups. The officer reviewed the camera and indicated the camera revealed what leadership had told the officer. The AP was seen on camera orally ingesting medications and had placed other medications in a medication cup and concealed them with other medications cups.

The AP's personnel file indicated the AP was trained and received competency testing for passing medications.

During an interview, unlicensed personnel (ULP) stated she found multiple medications hidden in a medication cup underneath other medication cups on top of the medication cart. The

medications found in the medication cup were lorazepam. The narcotics were not supposed to be taken out of the narcotic box early and left lying around. The on-call nurse was notified when the lorazepam was found.

During an interview, the registered nurse (RN) stated the ULP found lorazepam hidden in the medication cart. The medications found by the ULP was found in a medication cup, then had multiple medication cups stacked on top of it. The RN stated after being told about the medication, the camera footage was reviewed and found the AP took medications orally and had pocketed some medications. The RN was able to figure out what medications the AP had taken by looking at the narcotic cards and found the AP initialed and time stamped the medications on the card and then reviewed the camera footage. Multiple leadership staff also reviewed the camera footage, and the camera footage was given to the police. The RN stated the AP was trained on medication administration.

During an interview, leadership stated the camera footage showed the AP looked up at the camera, and then orally took medications. Leadership stated they made a phone call to the AP, however the AP did not answer or respond.

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 Adults interviewed: No. Not able to due to cognitive impairment.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No. Did not respond to subpoena.

Action taken by facility:

The AP is no longer employed by the facility following an internal investigation. The facility contacted law enforcement. The facility changed their process of passing narcotics which required two staff members to be present when administering a narcotic to a resident. In addition, the RN was to periodically review the cameras during a medication pass.

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
Isanti County Attorney
Isanti City Attorney
Isanti Police Department
Drug Enforcement Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30809	A. BUILDING: _____ B. WING _____	C 01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PSC OF ISANTI LLC	706 6TH AVENUE NE ISANTI, MN 55040

(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: HL308091642M / HL308093181C On January 24, 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 29 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL308091642M / HL308093181C, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 1 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure three of three residents (R1, R2, and R3) reviewed was free from maltreatment. R1, R2 and R3 were financially exploited. Findings include: The Minnesota Department of Health (MDH) issued a determination that financial exploitation occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	