Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308351520M
Compliance #: HL308359104C

Date Concluded: April 11, 2024

Name, Address, and County of Licensee Investigated:
Valleyview of Jordan, LLC
4061 West 173rd Street
Jordan, MN 55352
Scott County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Maerin Renee, 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), facility staff, financially exploited the resident when the AP stole hydrocodone/APAP (hydrocodone/acetaminophen), a narcotic pain medication commonly known as Norco or Vicodin, from the resident's personal supply.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP documented in the narcotic medication logbook she removed 10 tablets of Vicodin to administer to the resident. However, the AP did not document in the resident's MAR that the Vicodin had been administered, and the resident denied requesting or receiving Vicodin. In addition, the AP documented in the narcotic medication logbook that she dropped two tablets of Vicodin on the floor. However, nursing did not receive the two tablets of Vicodin, per protocol, and staff were unable to account for the missing Vicodin tablets.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident's records, pharmacy records, facility internal investigation, facility incident reports, facility medication records, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed medication administration to residents and staff/resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included left knee osteoarthritis. The resident's service plan included assistance with medication management. The resident's assessment indicated the resident was independent with activities of daily living and received assistance with housekeeping and laundry. The resident had no cognitive impairment.

The resident's physician orders indicated the resident was prescribed one tablet of hydrocodone/APAP (AKA Vicodin) every six hours for pain for management of an acute infection. The resident's clinic after-visit summary indicated her prescriber wrote a new order for one tablet of Vicodin to be taken by mouth every four hours as needed (PRN) for pain for up to ten days. The facility's narcotic logbook indicated the pharmacy dispensed 20 tablets of Vicodin (as the generic hydrocodone/APAP). The resident received one dose of Vicodin during the 10 days prescription was active. Staff documented in the resident's medication administration record (MAR) that one dose of Vicodin was administered to the resident.

The narcotic logbook indicated after the Vicodin prescription expired, the Vicodin was left in the medication cart and the order remained active in the resident's MAR. The resident's Vicodin count in the narcotic logbook remained at 19 for five months until the AP began to work at the facility. Over the course of two months, the AP documented in the narcotic logbook removing 12 tablets Vicodin. Three of the dates the AP documented in the narcotic logbook were scribbled and illegible. The resident's MAR indicated the AP did not administer Vicodin to the resident.

A police report indicated the resident said she never asked for Vicodin, the AP never administered it to her, and she did not even know it was still available for her. The resident stated she knew the difference between Tylenol and Vicodin. When interviewed by facility staff, the AP said she thought Vicodin could be administered like Tylenol. When staff asked the AP if she knew Vicodin was a narcotic medication, she responded that the medication label said "acetaminophen" on it. The AP reportedly did not respond when asked why the Vicodin was locked in the narcotic box if it was just Tylenol. When asked if the resident ever requested Vicodin, the AP said the resident had not. Staff told police the AP claimed to not know what "PRN" [as needed] meant, yet this information was covered in the AP's medication training, which she had passed.

The AP told police when she saw a medication card with the word "acetaminophen" on it in the narcotic lockbox, that is what she administered to the resident. When asked why she did not

document administering Vicodin to the resident in the resident's MAR, the AP said she could not find the medication in the system. The AP said there was no narcotic listed on the resident's MAR, only Tylenol. Police reviewed the resident's MARs and saw the Vicodin listed on the MAR during the time of the AP's tenure.

When interviewed, a nurse said staff discovered the AP signed out the resident's Vicodin in the narcotic logbook. It had been five months since anyone had signed out the resident's Vicodin. The AP documented signing Vicodin out in the narcotic logbook, but she did not document administering it in the resident's MAR. Vicodin tablets were also documented in the logbook as having been dropped on the floor, but nursing never received the tablets, per protocol. The resident told staff she never requested or received Vicodin from the AP, and she would know the difference between that and Tylenol. The nurse stated the AP said she administered the narcotic medication because she believed it was Tylenol. When asked if she questioned why Tylenol would be stored in the narcotic lockbox, the AP said she did not know, that was just what she thought it was. The nurse explained to the AP that Tylenol would not have a narcotic sticker on it and be stored in the narcotic lockbox and documented in the narcotic logbook if it was just Tylenol. The AP again said she just thought it was Tylenol. The AP previously documented administering PRN Tylenol to the resident three times in her MAR without incident. The nurse said she also recently completed competency testing with the AP, including medication administration (of scheduled and PRN medications), which the AP passed.

When interviewed, a supervisor said the AP, regardless of if she thought Vicodin was Tylenol, would have been expected to call a nurse or medical assistant before administering any PRN medication to a resident. The supervisor said the AP never called the appointed staff before she allegedly administered the PRN medication.

When interviewed, the AP said she was confused and did not intentionally do anything wrong. The AP said she administered Vicodin to the resident, thinking it was Tylenol. The AP checked the resident's narcotic medication, found Vicodin, which she said she mistook for Tylenol because the label had the word "acetaminophen" on it, and administered it to the resident. The AP said she did not pay attention to the label and did not document administering a PRN to the resident in her MAR. The AP said the electronic MARs had a PRN tab to document PRN medications, but she did not know about it. The AP said she did not document any resident's PRN medications in the electronic MAR until her last couple of weeks at the facility.

When interviewed, the resident said she never asked for nor received Vicodin. She had taken Vicodin previously and did not like how it made her feel. She requested Tylenol for pain and said she would know the difference between Tylenol and Vicodin.

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 Adult interviewed: Yes.
Family/Responsible Party interviewed: No, the resident is her own guardian.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation and contacted law enforcement. The AP is no longer employed at 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
Scott County Attorney
Jordan City Attorney
Jordan Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30835	A. BUILDING: _____ B. WING _____	C 03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEYVIEW OF JORDAN LLC	4061 WEST 173RD STREET JORDAN, MN 55352

(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: #HL308359104C/#HL308351520M On March 12, 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 48 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL308359104C/#HL308351520M, tag identification 2360.	0 000		
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.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident 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.	