Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL312503723M
Compliance #: HL312506110C

Date Concluded: January 11, 2023

Name, Address, and County of Licensee Investigated:
Elk Ridge Assisted Living SC
826 7th Avenue Southwest
Perham, MN 56573
Otter Tail County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Jill Hagen, RN,
Special Investigator

Finding: Substantiated, facility 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 facility financially exploited a resident by drug diversion when staff requested refills of oxycodone (opioid narcotic pain medication) for administration three times a day instead of the two times a day it was actually being administered to the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation by drug diversion was substantiated. Based on a preponderance of evidence, and lack of a facility narcotic tracking system, the facility was responsible for the maltreatment. The facility resolved the oxycodone order and increased the frequency of the administration to three times a day. However, during the investigation the resident's narcotic reconciliation log indicated one day the resident was missing 19 tablets of oxycodone. The facility lacked a medication system to prevent and/ or track drug diversion.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident medical record, physician orders, narcotic medication reconciliation forms, facility policy to ensure the security of narcotic medications, and staff schedules. Also, observation was made of the facility's electronic medical record, storage of medications including narcotic medications, and the facility practice for reconciliation and destruction of narcotic medications.

The resident resided in an assisted living facility with diagnoses including low back and leg pain. The resident's service plan included assistance with medication management including ordering, set-up, administration of medications to the resident, and prevention of drug diversion.

The resident's physician order included Oxycodone five milligrams (mg) three times a day for severe pain.

The resident's narcotic reconciliation documentation indicated during early morning shift change; two unlicensed personnel completed the resident's medication reconciliation for oxycodone. At that time, the resident had 108 oxycodone five mg tablets. Approximately three hours later, one of those unlicensed staff reconciled the oxycodone count at 89, indicating 19 oxycodone were missing.

When interviewed, the unlicensed staff stated she was working one morning with the resident and the facility registered nurse removed some of the resident's oxycodone tablets. The nurse didn't document (reconcile) removing the oxycodone, so the unlicensed staff updated the current count of the oxycodone after the nurse removed 19 oxycodone. The unlicensed staff denied taking the oxycodone tablets for her own use.

The resident's medication administration record (used to document medications administered to the resident) had no documentation the resident received any oxycodone during the three-hour time frame 19 oxycodone were removed from the resident's personal medication supply.

During an interview, several unlicensed staff stated two staff were required to reconcile the narcotic medications at shift change. If a narcotic medication count was incorrect, staff were directed to report the concern to the registered nurse.

When interviewed the registered nurse stated staff did not notify her of the resident's missing oxycodone tablets and she denied taking the residents oxycodone medication. The nurse stated an incident report should have been filled out, and a facility investigation should have been completed related to the resident's missing oxycodone tablets.

In conclusion, the Minnesota Department of Health determined 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
(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.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility updated medication policy and procedures.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.
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 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Otter Tail County Attorney
Perham City Attorney
Perham Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31250	A. BUILDING: _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELK RIDGE ASSISTED LIVING SC	826 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: #HL312506294C/#HL312503786M and #HL312506110C/#HL312503723M 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 6 residents receiving services under the provider's Assisted Living license. The following immediate correction orders are issued for #HL312506294C/#HL312503786M and #HL312506110C/#HL312503723M, tag identification 1690. The immediacy was removed from tag 1690 on December 16, 2022. Non-compliance remained at a scope and severity of a F.	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 The following correction orders with a time period to correct are issued for #HL312506294C/#HL312503786M and #HL312506110C/#HL312503723M, 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 (R1 and R3) residents reviewed. 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:	0 720		

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0 720	Continued From page 2 R1 was admitted to the facility on July 3, 2022, with diagnoses including malignant tumor of the left breast, pressure injury of the buttocks, and spinal stenosis of the lumbar region. R1's facility assessment dated December 2, 2022, indicated R1 required medication management services, and reported no pain. R1's medication administration record (MAR), administration documentation, tracking of the hydromorphone drug including shift to shift counts, and disposition of the hydromorphone medication was requested, for June 2022, to November 2022. The facility only provided R1's MAR for November 2022, which failed to include the residents physician order for hydromorphone, despite the medication not being discontinued until November 2, 2022, by R1's provider. R3's Care Plan dated October 8, 2022, indicated R3's diagnoses included congestive heart failure, depression, and chronic pain. R3 required staff assistance with medication management including set-up and dispensing medications to R3. Despite numerous requests from the surveyor, the licensee failed to provide R3's MAR for June through October 2022. R3's medication administration record (MAR) dated November 2022, indicated R2 received Oxycodone 5 mg three times a day at 8:00 a.m., 2:00 p.m., and 8:00 p.m. R3's Pill Count History for Oxycodone 5 mg tablets from September 1, 2022 through December 2, 2022, was reviewed. On October 21, 2022, at 6:32 a.m. two unlicensed	0 720		

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0 720	Continued From page 3 professionals (ULP)'s completed a reconciliation (count) of the narcotic medication for shift change and indicated 108 Oxycodone tablets remaining. At 9:07 a.m., ULP-D documented a medication recap which indicated 89 Oxycodone tablets remained. The licensee failed to provide additional records for R3 for the October 21, 2022, narcotic medication discrepancy. No further information was provided by the licensee. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 720		
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,	01690		

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01690	Continued From page 4 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 accountability of controlled substances for two of two residents (R1 and R3), reviewed with missing narcotic medications. R1 had 720 hydromorphone tablets, and R3 had 19 oxycodone tablets, (both narcotic medication) dispensed by the pharmacy and delivered to the facility. The facility had no documentation of receiving or administering R1 or R3's narcotic pain medication. The facility failed to ensure medication management policies and procedures were developed under the supervision and direction of a registered nurse (RN), licensed health professional, or pharmacist consistent with current practice standards. The facilities lack of systems to prevent narcotic diversion had the potential to affect all current and future residents prescribed narcotic medication. The facility's lack of medication systems to prevent narcotic diversion resulted in an immediate correction order on December 8, 2022. The immediacy was removed on December 16,	01690		

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01690	Continued From page 5 2022, when the facility updated medication policy's and procedures and educated staff. 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 the residents). Findings include: R1 was admitted to the facility on July 3, 2022, with diagnoses including malignant tumor of the left breast, pressure injury of the buttocks, and spinal stenosis of the lumbar region. R1's facility assessment dated December 2, 2022, indicated R1 required medication management services, and reported no pain. R1's facility care plan updated by registered nurse (RN)-A on November 22, 2022, indicated the resident required assistance with medication administration, monitoring, and documentation of medications. R1's care plan indicated the resident required full medication management setup. The RN would consult and clarify instructions and changes from the provider, and a review of medications would be completed by the RN including a review of medications prescribed with the provider and Pharmacy. R1's outside medical record included information from January 2022, to November 23, 2022. A	01690		

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01690	Continued From page 6 note from a Hospital Encounter dated September 24, 2022, indicated R2's active medications included hydromorphone (Dilaudid), 2 mg Tablets, with no date to identify when/ if the prescription would end. The outside medical record contained a faxed medication list for R2 from RN-A on November 1, 2022, at 2:59 p.m., which included hydromorphone 2 mg as needed (PRN), up to three times daily with a start date of February 27, 2022, which indicated the date R2 was initially prescribed the hydromorphone. The record included an encounter dated November 2, 2022, at 12:00 p.m. which indicated R2's provider was at the facility to follow up on her pressure injury and diabetes. The record included a fax from the facility RN-A with R1's current medication list as of November 1, 2022, the med list included hydromorphone 2 mg for pain or discomfort as needed; with instruction to take one tablet by mouth up to three times daily, at least four hours apart. The encounter note indicated the resident had chronic pain but denied pain when assessed. The provider ordered to discontinue the medication and ordered a drug screen to be completed for R2. A review of the record indicated the drug screen was never completed by the facility. R1's medication administration record (MAR), administration documentation, tracking of the hydromorphone drug including shift to shift counts, and disposition of the hydromorphone medication was requested, for June 2022, to November 2022; however, the facility only provided R1's MAR for November 2022, which failed to include the resident had a physician order for hydromorphone, despite the medication not being discontinued until November 2, 2022, by R2's provider.	01690		

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01690	Continued From page 7 R1's facility Pill Count History Report from September 1, 2022, to December 2, 2022, contained no documentation of hydromorphone ever being entered into the resident record or counted. R1's facility progress notes from June 1, 2022, to December 2, 2022, lacked any documentation of hydromorphone being administered, ordered, or received by the facility. On December 7, 2022, at 12:59 p.m. Pharmacy Director (PD)-F stated RN-A called the pharmacy for refill's of R2's hydromorphone. The pharmacy would then contacted R2's provider, who would send the electronic prescription to the pharmacy. After the medication was filled, it was either delivered to the facility or picked up by an employee of the facility. The Pharmacy provided Monthly Audit Logs which indicated R1 had received eight refills of 90, 2 mg tablets of hydromorphone, from March 3, 2022, to October 26, 2022. The electronic prescriptions included the following: - Prescription number 12009542, filled and received by the facility on March 21, 2022. - Prescription number 12009561, filled and received by the facility on April 12, 2022. - Prescription number 12009576, filled and received by the facility on May 3, 2022. - Prescription number 12009604, filled and received by the facility on May 23, 2022. - Prescription number 12003698, filled and received by the facility on August 11, 2022. - Prescription number 12009735, filled and received by the facility on September 13, .2022. - Prescription number 12009757, filled and received by the facility on September 29, 2022. - Prescription number 12009779, filled and received by the facility on October 26, 2022.	01690		

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01690	Continued From page 8 The pharmacy provided Service Delivery Sheet dated September 29, 2022, Included the prescription number 12009757 for R1 with 90 tablets received by RN-A; signed for and dated September 29, 2022. During observation on November 29, 2022, at 12:42 p.m. RN-A opened a locked cabinet in her office which contained two separate bubble pack cards (90 tablets) of R1's hydromorphone 2 mg tablets prescription number 12009779, dated October 26, 2022. RN-A stated there was no process for tracking controlled drugs once they entered the facility and controlled drugs were not counted or tracked until the narcotic medication was added to the resident's MAR, at which time the narcotic would be added to the count in the medication cart. RN-A indicated she continued to reorder R1's hydromorphone because that was what she did in the previous electronic medical record system. RN-A stated the dilaudid and other narcotic medications which were locked in her office were not tracked or counted. RN-A indicated she did not know what happened to R1's seven other hydromorphone prescriptions (630 tablets), the pharmacy had record of dispensing to the facility for administration to R1. RN-A stated R1's physician ordered drug screening was not done, and indicated there would be no hydromorphone detected in R1's system because she was not receiving the hydromorphone. On December 1, 2022, at 12:05 p.m. licensed practical nurse (LPN)- C stated one day a staff called from R1's building and state hydromorphone was dropped off by the pharmacy for R1. LPN-C stated when she went to log the narcotic medication into the system, a staff	01690		

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01690	Continued From page 9 member stated unlicensed personnel (ULP)-B took the hydromorphone because R1 was "allergic" to it. LPN-C stated hydromorphone was never on R1's MAR, and when she reviewed R1's medical record she found the medication listed on the resident's medication list to the provider, but not on her MAR for it to be administered to R1. LPN-C stated she called the pharmacy and was informed the resident had received regular refills of hydromorphone, however, LPN-C had never seen hydromorphone on R1's MAR, and LPN-C had no knowledge hydromorphone had ever been ordered for R1. LPN-A stated RN-A added the hydromorphone order to R1's MAR on November 1, 2022, after concerns of narcotic drug diversion were brought forward to the facility by law enforcement. The hydromorphone was discontinued by the physician the following day, November 2, 2022. R1's facility records lacked documentation of R1's hydromorphone prescribed to the resident. The facility failed to enter the medication onto the residents MAR for administration, and failed to ensure the medication was tracked and counted by the facility to prevent diversion. In addition, the facility documentation lacked disposition and destruction of the hydromorphone to prevent and/or track drug diversion. R3 During observation on November 29, 2022, at 11:15 a.m., the licensee narcotic medication central storage consisted of two locked upper cupboards in the main community room. Unlicensed Personal (ULP)-D unlocked the cupboards and removed a smaller box secured with a dial code. The box contained R3's oxycodone medication. ULP-D stated staff keep	01690		

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01690	Continued From page 10 track of the number of narcotic medications with an electronic reconciliation system. R3's Care Plan dated October 8, 2022, indicated R3's diagnoses included congestive heart failure, depression, and chronic pain. R3 required staff assistance with dressing, bathing, meal preparation, and medication management including set-up and dispensing medications to R3. R3 required a wheeled walker for ambulation. The care plan indicated R3 experienced throbbing pain of the legs and low back and received scheduled oxycodone (opioid medication), which was locked and secured in the facilities central location. R3's MD (Medical Doctor) orders with an initiation date of May 26, 2022, indicated the resident was prescribed oxycodone 5 milligrams (mg), three times a day for severe pain. R3's Pill Count History for oxycodone 5 mg tablets from September 1, 2022 through December 2, 2022, was reviewed. On October 21, 2022, at 6:32 a.m. two unlicensed professionals (ULP)'s completed a reconciliation (count) of the narcotic medication for shift change and indicated 108 oxycodone tablets remaining. At 9:07 a.m., ULP-D documented a medication recap which indicated 89 oxycodone tablets remained. There was no additional documentation regarding the 19 missing oxycodone tablets. R3's medication administration record (MAR) dated November 2022, indicated R2 received oxycodone 5 mg three times a day at 8:00 a.m., 2:00 p.m., and 8:00 p.m. During interview, on November 29, 2022, at 11:15	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31250	A. BUILDING: _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELK RIDGE ASSISTED LIVING SC	826 7TH AVENUE SW PERHAM, MN 56573

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01690	Continued From page 11 a.m., ULP-D stated at the end and beginning of every eight-hour shift, two staff members reconcile the narcotic medication count. ULP-D stated when the pharmacy delivered narcotic medications to the facility the staff put the medication in the small, locked box and notify RN-A of the delivery. RN-A would enter the medication and count into the electronic documentation for narcotics. ULP-D stated if the narcotic count was incorrect, staff were educated to report the inconsistent count to RN-A. ULP-D stated all staff have access to the narcotic medication. During an interview on December 6, 2022, at 8:41 a.m., RN-A stated staff failed to notify her of R3's 19 missing doses of oxycodone. Review of the licensee's policy and procedure titled Medication Storage with a revised date of August 1, 2021, indicated, when medications were managed and stored by the licensee, medications would be kept securely locked and stored per manufacturer's directions. Only authorized staff would have access to stored medications. The policy stated, "Optional but suggested to protect staff and minimize diversion": Schedule II drugs would be stored under a double lock system and stored separately from other medications. Schedule II drugs would be counted at the beginning and end of every shift, with counts compared to Schedule II medications ordered to be administered. The policy lacked processes to prevent diversion including logging-controlled drugs into the facility, ensuring accuracy of medication ordered on the resident's MAR, documenting medication administration, reporting concerns with inaccurate medication reconciliation, and documentation of disposition of medications including witnessed	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01690	Continued From page 12 destruction of controlled drugs to prevent diversion. No further information was provided by the licensee. 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 two of two residents reviewed (R1 and R3) were 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 R1, and the facility was responsible for the maltreatment of R3, 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.	