Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL318842523M
Compliance #: HL318844375C

Date Concluded: May 23, 2023

Name, Address, and County of Licensee Investigated:
River Oaks at Lake Pepin
815 North High Street
Lake City, MN 55041
Wabasha County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lissa Lin, 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) financially exploited the resident when she took and ingested the resident's prescribed narcotic medication while at work.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. Facility surveillance video showed the AP take and ingest the resident's prescribed controlled anti-anxiety medication (lorazepam) twice while she prepared resident medications.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the Resident's family member and guardian. The investigation included review of surveillance video, resident records, policies and procedures, personnel files, incident reports and staff schedules. Also, the investigator observed the resident receive her morning medications.

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The resident resided in an assisted living facility. The resident's diagnoses included generalized anxiety disorder, bipolar disorder, delusional disorders, and borderline intellectual function. The resident received medication management and administration which included a regimen of psychotropic medications to help with mental health issues. One of the medications was lorazepam, a controlled anti-anxiety medication.

The resident's assessment indicated she had a history of elopements and self-injurious behaviors. The resident was assessed as often weepy and received 1:1 staff support to help her with coping skills.

The nurse manager stated she received a concern a staff member was braiding another staff members' hair while they worked on the floors. The nurse said that was not appropriate behavior and reviewed the facility surveillance cameras. While she reviewed the cameras, she saw the AP at one of the medication carts. The AP removed a pill from its punch card and popped the pill into her mouth. The nurse called management, the police, and the resident's guardian. Management removed the AP from the floor and waited with her in an office until police arrived.

The nurse said she reviewed additional surveillance camera footage and saw the AP had taken a dose of the resident's lorazepam a day earlier, also while she prepared medications at the medication cart. The nurse said the resident may have been slightly more agitated on the days the AP diverted the lorazepam.

During an interview, the manager said she observed the surveillance camera footage of the AP diverting drugs and she told the nurse to remove her from working on the floor. The manager said the AP admitted she took the resident's lorazepam. Police arrived and took the AP for questioning. The manager said the AP's employment was terminated and they implemented a new medication policy requiring two staff sign for narcotic medications.

Review of surveillance video showed the AP at a medication cart. She took a pill out of a medication punch card and held it in her left hand. The AP then walked away from the medication cart and into a medication or utility room across the hall, put her and up to her mouth, then walked back to the medication cart and drank liquid from a small cup.

Review of surveillance video from the next day showed the AP at a medication cart. She had a medication punch card in her hands. She pushed in the back of the punch card, then pulled the paper backing away and tipped the card sideways. One pill fell out. The AP picked up the pill with her left hand, looked towards a surveillance camera, turned away and lifted her hand to her mouth, then turned back to the medication cart and drank from a can.

Review of police reports indicated the AP said she had a “really bad day”, and “a bad lapse in judgement”. The AP stated she only took one pill one time and her own prescription medication for anxiety was not useful.

The AP said she had been to court on the matter and declined a phone interview.
Review of the AP’s records indicated she received training on vulnerable adults, identifying and reporting abuse, neglect, and financial exploitation. Court records showed the AP pled guilty to felony theft and was placed on probation and had to successfully complete substance abuse court.

The resident’s guardian did not participate in a scheduled phone interview and did not respond to requests to reschedule.

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;

Vulnerable Adult interviewed: No, due to mental health issues.
Family/Responsible Party interviewed: Attempted, Guardian did not answer a scheduled phone call, did not respond to requests to reschedule call.
Alleged Perpetrator interviewed: No, declined an interview.

Action taken by facility:
The facility conducted an internal investigation, contacted policy and updated the medication administration policy on administering narcotics. The AP is no longer employed by the facility.

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
Wabasha County Attorney
Lake City City Attorney
Lake City Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31884	A. BUILDING: _____ B. WING _____	C 03/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS AT LAKE PEPIN LLC	815 NORTH HIGH STREET LAKE CITY, MN 55041

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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: #HL318843230C/#HL318841661M, #HL318844375C/#HL318842523M On March 21, 2023 through March 22, 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 33 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL318844375C/#HL318842523M, tag identification 0700, 2310 and 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 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 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 evaluators' 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 SUBDIVISION 1-3.	
0 700 SS=E	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or	0 700		

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0 700	Continued From page 1 electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on record review, observation and interview, the licensee failed to ensure resident records were secured and protected against unauthorized disclosure for two of four residents (R3 and R4) reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and was issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: R3's diagnoses included undifferentiated schizophrenia and type 2 diabetes. R3's service plan agreement, dated January 9, 2023, indicated R3 received daily medication set up and administration. R4's diagnoses included schizophrenia, depression, type 2 diabetes. R4's service plan agreement indicated he received assistance with medication administration including help with dialing up his insulin doses and checking his	0 700		

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0 700	Continued From page 2 blood glucose daily. During an observation at 12:05 p.m. on March 21, 2023, a medication cart computer screen was open to R3's medication administration record (MAR) and displayed R3's scheduled citalopram prescription. The cart was unattended and near a busy hallway and side entrance. Four individuals passed the medication cart and exposed medication information on the computer screen over approximately 30 seconds. During an observation at 7:23 a.m. on March 22, 2023, a medication cart computer screen was open to R4's MAR and displayed R4's scheduled polyethylene glycol, tamsulosin and tramadol prescriptions while unlicensed personnel (ULP)-E was in R4's room. ULP-E said he should have minimized the computer screen before walking away. During an interview on March 21, 2023 at 12:05 p.m., unlicensed personnel (ULP)-A said she was assigned to the other medication cart down the hall but no the resident's medication information should be up on the computer screens unattended. During an interview on March 21, 2023 at 12:30 p.m., ULP-D said computer screens should be minimized when staff walk away from the medication carts. Review of a policy titled Security of Resident Records, dated July 26, 2021, indicated all information in the resident record must be kept confidential and accessible only to authorized agency personnel. Electronic health records and devices such as laptops, flash drives, etc. will be kept secured.	0 700		

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0 700	Continued From page 3 TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 700		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure competent staff provided cares for one of one resident (R1) reviewed when unlicensed personnel (ULP)-H diverted two of R1's lorazepam tablets and ingested them while at work. (Lorazepam is a benzodiazepine used to treat anxiety disorders, sleep problems, agitation and active seizures and a controlled substance.) This had the potential to impact other residents whom ULP-H provided cares for. 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, but was not likely to cause 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). The findings include:	02310		

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02310	Continued From page 4 R1's diagnoses included generalized anxiety disorder, major depressive disorder severe with psychotic features, delusional disorders and bi polar disorder. R1's service agreement dated December 12, 2022, indicated R1 received wellness checks, behavior management and medication management, including medication set up, reminders and administration. R1's assessment for client vulnerability, safety and risk to others dated October 7, 2022, indicated R1 was on a regimen of psychotropic medications to help with mental health symptoms. R1's medication list dated March 21, 2023, included an order for lorazepam 1 milligram (mg) tab three times daily with directions to give 1 and 1/2 tablets by mouth three times a day Review of R1's medication adminstration record (MAR) dated August 2022. On August 18, 2022 and August 19, 2022, ULP-H initialed she administered 1.5 mg of lorazepam during the morning. R1's medication incident report dated August 19, 2022, at 6:45 a.m., indicated a medication diversion had occurred. R1's morning dose of 1.5 mg of lorazepam was not given due to observation of staff member attempting to punch the narcotic out into her hand and it dropped onto the medication cart. Staff member them picked up the medication, turned away from the camera and put the medication in her mouth. The director of nursing (DON)-G discovered the incident. ULP-H was the staff member involved. DON-G notified R1's family, the pharmacy, the physician and the care team. ULP-H was immediately	02310		

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02310	Continued From page 5 removed from her duties and placed under supervision until the vice president of operations (VP)-C arrived. Police were notified of the situation. ULP-H admitted to diverting the medication. Upon investigation, the incident had happened at least once before with ULP-H. No adverse outcome for R1. Review of facility surveillance video, dated August 18, 2022, at 06:51 a.m., showed ULP-H at a medication cart preparing a medication while she talked with ULP-A, who moved out of camera range. ULP-H pulled a medication punch card from a drawer on the medication cart, typed on the computer, wrote on the medication card, greeted a resident who walked past her, then pushed on one of the punch card bubbles and extracted a pill, which ULP-H kept in her left fist as ULP-A approached the medication cart and then went into the medication room across the hall. ULP-H kept the medication in her left fist while she talked with ULP-A. At 06:52 a.m. ULP-H and ULP-A standing at the medication room doorway. ULP-H's back was to the camera. She leaned against the door frame, her right hand on the door frame, her left fist closed at her side as she and ULP-A talked. The two moved into the hallway and ULP-A moved out of camera view, while they talked about sending pictures to someone. At 06:53 a.m., ULP-H appeared to be alone in the hallway and walked into the medication room. At video timestamp 06:53 a.m. ULP-H's left arm moved up and forward. She took a few steps into the medication room towards the sink, then turned around and walked out of the room. Her left hand was unclenched. Someone spoke out of camera view. ULP-H smiled, said I know, returned to the medication cart and took a sip of liquid from a small plastic cup.	02310		

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02310	Continued From page 6 Review of facility surveillance video dated August 19, 2022 at 06:45 a.m., showed ULP-H at the medication cart. She wore a surgical mask. A maintenance staff member (M)-L stood at the medication cart and talked to ULP-H for 15 seconds before he left and went around the corner. ULP-H had a medication punch card in her hands. She pushed in on the back of the bubble punch card, then poked or pulled at the paper backing. ULP-H tipped the card up and sideways. One round light colored pill fell onto the medication cart near a medication cup that already contained pills and tablets. ULP-H continued to joke with M-L, who was still around the corner. ULP-H picked up the pill with her left hand. ULP-H pulled her surgical mask down below her chin and turned towards the camera, looked at it, then turned away and lifted her left hand up to her mouth. She turned back to the medication cart and took a drink from a can of energy drink. She pulled the surgical mask up over her mouth and continued to joke with M-L who was still around the corner and out of view. ULP-H ripped away part of the medication bubble pack and threw it away. At 07:29 a.m., the video showed ULP-H at a medication cart documenting in a narcotic log book. Two staff members approach ULP-H, both wore surgical masks. One staff member asked ULP-H something about stepping away (audio is faint) and ULP-H said ok. A police report narrative dated August 19, 2022, indicated an officer received a theft of medication report. He arrived and spoke to vice president of operations (VP)-C who told him ULP-H took a lorazepam pill after dispensing a resident's medication. VP-C showed police the video of ULP-H taking the pill out of the medication punch card and putting it in her mouth. VP-C said	02310		

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02310	Continued From page 7 ULP-H was in her office. VP-C said the medication was prescribed to R1 and it was a 1 mg lorazepam tablet. VP-C said ULP-H was suspended and could not return to work. Police advised ULP-H he was taking her to the police department for an interview. VP-C called the police officer later and said ULP-H also took a 1 mg lorazepam pill on August 18, 2022 and they would audit their video to see if there were more incidents of her taking medications. VP-C gave the police a flash drive of the videos and said they were broken up [into video clips] but explained them to the officer. At 8:39 a.m., ULP-H told police she had a "really, really bad day", had a bad lapse in judgement and had things going on in her personal life that pushed her over the edge with panic. ULP-H told police she did take one Lorazepam pill, but just one, and just one time. She was dispensing medications to the residents at the time of the incident. She said was on depression and anxiety medications, but the anxiety medication was not helpful. Review of the State of Minnesota Disposition Bulletin, dated December 19, 2022 to December 26, 2022, indicated ULP-H pled guilty to felony theft and was placed on 5 years supervised probation. During an interview on March 22, 2023, at 12:50 p.m., director of nursing (DON)-G said she was reviewing surveillance video because she heard a staff member from housekeeping was braiding ULP-H's hair in the hallway and that was not appropriate. DON-G said that is when she saw ULP-H pop a narcotic medication into her mouth. She witnessed a second episode of ULP-H doing that. The police were called. ULP-H was pulled off the floor and placed into DON-G's office until	02310		

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02310	Continued From page 8 police arrived. DON-G said she was not aware of any negative impact on R1, she may have been slightly more agitated that day, but mental health is day to day. During an interview on April 17, 2023 at 1:30 p.m., VP-C said she was called by DON-G. LALD-B was out on vacation so she came to the facility. She said ULP-H admitted to her and DON-G that she took R1's lorazepam. VP-C said ULP-H was termed from her employment, staff were re-educated, and a new narcotic med book policy was created that required two staff signatures on the day and evening shifts. A policy titled Vulnerable Adult Maltreatment Policy, dated August 1, 2021, indicated any staff who witness or suspect maltreatment of a vulnerable adult will report the incident immediately to their supervisor. If the incident appears to be suspected abuse, neglect or financial exploitation the nurse, social services LALD or designee will immediately make a report to the common entry point (CEP). TIME PERIOD TO CORRECT: Seven (7) Days	02310		
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: Based on observations, interviews, and document review, the facility failed to ensure one of 30 residents reviewed (R1) was free from	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details	

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02360	Continued From page 9 maltreatment. R1 was financially exploited. Findings include: On March 21, 2023, the Minnesota Department of Health (MDH) issued a determination that financial exploitation occurred, and that the individual staff 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	of this tag.	