Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL325878125M
Compliance #: HL325875187C

Date Concluded: November 3, 2023

Name, Address, and County of Licensee Investigated:
The Sanctuary at West St Paul
1746 Oakdale Avenue
West St Paul Minnesota 55118
Dakota County

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

Evaluator's Name: Holly German, 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 a resident when they took the residents medication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP was the only nurse in the medication storage cabinet for the third floor during the shift and had a history of drug diversion allegation at a previous employer. The AP left her shift early and did not complete the narcotic count with the incoming shift.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a previous employer of the AP. The investigation included review of the resident's medical record, facility narcotic count logs,

staff schedules, facility policies, an internal investigation report, the AP's personnel file. Also, the investigator observed change of shift narcotic count at a medication cart.

The resident resided in an assisted living facility. The resident's diagnoses included fibromyalgia and chronic pain syndrome. The resident's service plan indicated she was independent with activities of daily living and reordered her own medications from the pharmacy. The resident's assessment indicated she was alert and orientated and received assistance with medication administration.

The facility narcotic count log indicated the medication count was accurate at the start of the shift. At the end of the shift, a whole card, 30 tablets of oxycodone (a narcotic pain medication) was missing.

The internal investigation indicated the AP was the only staff member to access the third floor medication storage unit during the shift. The facility performed a thorough search throughout the facility but did not locate the medication. The facility installed cameras in the medication storage room after the incident.

During an interview, a nursing supervisor staff member stated a thorough search was conducted for the medication and it was never located. She stated she contacted the AP by phone after she discovered that she was no longer in the building and asked her if she had removed one or two narcotic medication cards from the storage cabinet that day. She stated the AP told her just one, and she did not know where the missing medication card could be. She did not recall the AP previously stating to her that she would be leaving her shift early. The nursing staff member stated she did not ask the AP if she took the medication.

During an interview, the AP's previous employer stated the AP had an allegation of drug diversion at that facility and the AP was no longer employed.

During investigative interviews, multiple staff were able to state the facility policy and procedure for controlled substance correctly.

During an interview, the AP stated she did not take the medication. The AP stated she was not involved in any previous drug diversion allegations at any other facilities. The AP stated she had told a supervising staff member she had to leave early to attend to a family matter.

During an interview, the resident stated she was not aware her medication was missing. The resident confirmed her pain medication had always been available to her when she requested it.

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:
(1) willfully uses, withholds, or disposes of funds or property of a 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

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation and installed security cameras in the medication storage area.

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
Dakota County Attorney
West St Paul City Attorney
West St Paul Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32587	A. BUILDING: _____ B. WING _____	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT WEST ST PAUL	1746 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

(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: #HL325875187C/#HL325878125M #HL325879556C/#HL325875543M On October 5, 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 148 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL325875187C /#HL325878125M, tag identification 2360.	0 000	Minnesota Department of Health is documenting 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 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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 one of one resident(s) reviewed (R1) was free from maltreatment. The 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		