Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL345968205M
Compliance #: HL345965373C

Date Concluded: October 10, 2023

Name, Address, and County of Licensee Investigated:
Mills Manor
215 Tousley Ave South
New York Mills, MN 56567
Otter Tail County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, 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):
An unlicensed staff member/alleged perpetrator (AP) financially exploited a resident (Resident #1) when the AP took the Resident #1's Oxycodone (narcotic medication) for her own personal use. The same unlicensed staff member/alleged perpetrator (AP) also financially exploited another resident (Resident #2) when the AP took the Resident #2's Morphine (narcotic medication) for her own personal use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The unlicensed staff member/alleged perpetrator (AP) was responsible for the maltreatment. During a shift change, it was noted the narcotic count was off for two residents (Resident #1 and Resident #2). The facility registered nurse (RN) was notified and law enforcement was contacted. The oncoming unlicensed personnel (ULP) and the outgoing AP were asked to stay at the facility until an investigation could be completed to determine what happened to the two narcotics. Law enforcement interviewed the AP, who admitted to consuming both pills. Security

camera footage showed the AP opening the narcotic box and then going to the break room. The AP was arrested and terminated from the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement. The investigation included review of facility policies and procedures, resident medical records, the AP's employee record, and the police report. Also, the investigator observed medication administration and narcotic storage at the facility.

Resident #1 resided in an assisted living facility. Resident #1's diagnoses included type two diabetes, dementia, and memory loss. Resident #1's service plan included assistance with medication administration. Resident #1's assessment indicated the resident had chronic pain and used scheduled medications for pain management. Resident #1 was dependent on staff to administer her medications.

Resident #2 resided in an assisted living facility. Resident #2's diagnoses included spastic quadriplegic cerebral palsy (a form of cerebral palsy that impacts all four limbs) and pulmonary emphysema (lung disease that causes shortness of breath). Resident #2's service plan included assistance with medication administration. Resident #2's assessment indicated the resident received hospice services and had occasional pain. Resident #2 was dependent on staff to administer medications.

The police report indicated officers were called to the facility after the narcotic count was off during a change of shift and a 5 mg tablet of Oxycodone and a 5 mg tablet of Morphine were missing. The responding officer met with ULP working at the time and advised the AP he wanted to speak with her regarding the missing pills. After initially denying taking the narcotics, the AP told the officer she hated working on the medication cart. The AP indicated she had specifically requested to not be on the cart but was "forced to be on the cart." The AP told the officer being around the pills was a temptation for her, as she had been addicted to them in the past. The AP admitted to the officer she had consumed both pills. Security footage showed the AP opening the narcotic box at 11:28 a.m., when no narcotics were scheduled to be given. The AP was then seen going to the break room. A search warrant to check the AP's blood for the presence of narcotics was conducted. The AP was booked and later released on charges of theft of narcotics.

During an interview, the facility registered nurse (RN) stated she was notified by ULP after the narcotic count from day shift to the oncoming evening shift was off for two residents. The RN stated she advised to all employees that no one could leave until the discrepancy was resolved and law enforcement was notified. The RN stated that based off the AP's body language and behavior, they were suspicious of the AP and thought she might have had some involvement with the missing narcotics. The RN stated the responding police officer interviewed the AP who admitted to the officer she had taken the two narcotic medications.

During an interview, the AP stated she did not recall much from that day. The AP was asked if she took the medications and stated, “It happened, whatever, I guess. I kind of blacked out, but, yeah.” The AP added “either way, I’m disqualified, so just disqualify me.”

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: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility immediately reported the incident to MAARC and local law enforcement. The employee was immediately terminated.

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
Otter Tail County Attorney
New York Mills City Attorney
New York Mills Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34596	A. BUILDING: _____ B. WING _____	C 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLS MANOR	215 TOUSLEY AVENUE SOUTH NEW YORK MILLS, MN 56567

(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: #HL345968205M/ #HL345965373C On September 22, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 23 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL345968205M/ #HL345965373C, 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 residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the alleged perpetrator (AP) 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.	