Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL350512741M
Compliance #: HL350512261C

Date Concluded: July 18, 2024

Name, Address, and County of Licensee Investigated:
The Lodge
107 Bridgewater Way
Stillwater MN, 55082
Washington County

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

Evaluator's Name: Kris Detsch, 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 resident's Percocet (narcotic) medication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP counted narcotic medications at the beginning of her shift and the narcotic medication count was correct. The AP counted narcotic medications at the end of her shift and three narcotic pills (Percocet) were unaccounted for. A staff member saw the AP tape pills into a medication card during the shift. The AP said she did not go into the narcotic box for the entirety of her shift, but camera images showed the AP entered the narcotic box multiple times during the shift.

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 resident records, employee files, narcotic logs, law enforcement reports, and the facility's internal investigation. Also, the investigator observed multiple staff members count narcotic medications, administer medications, and the facility's record keeping systems.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease and cancer. The resident's service plan included assistance with medication management. The resident's nursing assessment indicated her health was declining, and she required narcotic medication to manage her pain.

During an interview, a manager said she received a call during the night because the nighttime unlicensed personnel (ULP) noticed a discrepancy when they counted narcotic medications with the AP. The ULP noticed there was a Percocet pill missing from the resident's medication card of Percocet. Additionally, there were two pills taped into the resident's medication card, but the two pills were not Percocet. The manager said prior to the AP's shift, the narcotic medication count was correct. The manager said the AP told her she cleaned out the narcotic box, because she did not want germs in there, and found two pills in the bottom of the narcotic box. She taped them into the resident's medication card (containing Percocet). The manager said the AP told her she thought it was the right thing to do. The manager said the pills were Tylenol, not Percocet. The facility does not keep Tylenol in the narcotic compartments of the medication carts. The manager said there were multiple cards of narcotic medications in the locked narcotic box and the AP was unable to explain why she chose to tape the Tylenol pills into the resident's card of Percocet as opposed to any of the other cards located in the narcotic box. The manager said the resident was not in the facility at the time of the incident because she was out of town receiving treatments for cancer. The manager said she reviewed images from the facilities cameras and noticed the AP was in the narcotic compartment "a lot" during the shift, but the images were inconsistent with medication administration. The manager said the AP was a new employee and only worked a few shifts prior to this incident. The manger said she contacted law enforcement, and terminated the AP. The facility ordered Percocet for the resident to replace the three missing pills.

During an interview, the ULP working with the AP at the time of the incident said there were two medication carts on the unit. The medication carts have keys to unlock the carts, and the compartments for narcotics. Each medication cart has its own locked box for narcotic medications. The keys only unlock one cart, not the other. The AP was the only staff member during the shift, who had the keys to unlock the narcotic box in the medication cart where the discrepancy occurred. The ULP said there were no discrepancies when they counted narcotic medications at the beginning of the shift. The ULP said at the end of the shift they counted narcotics with the oncoming shift and the oncoming staff member noticed there was a pill missing from a medication card in the AP's cart. The ULP said then she also looked at the card of Percocet and noticed two pills in the card, secured by tape. The two pills looked different than the other pills. In addition, to a missing pill. The AP told her she found loose pills and taped them in the medication card.

During an interview, the AP said she counted narcotic medications with the ULP at the start of her shift. When they counted at the beginning of the shift, the AP said there were two pills taped into the resident's card of Percocet and the ULP told her to re-tape the pills if the tape came off. The AP said the medication count was correct at the start of her shift. The AP said she did not go into the locked narcotic box for the entirety of her shift. The AP said when she counted the narcotics at the end of her shift the tape came loose from the two pills, and she re-taped them into the card. The AP said the morning shift documented in the narcotic book they gave the resident two Percocet before she left the facility in the morning. The resident did not return to the facility until after her shift.

Narcotic medication logs indicated facility staff members consistently counted narcotic medications between shifts. There were no discrepancies within the narcotic counts until the end of the AP's shift. The narcotic logs indicated the AP counted narcotics with the ULP at the beginning of her shift and the narcotic medication count was correct. The resident's narcotic log indicated the last time she received a Percocet was on the evening shift, one day prior to this incident. Additionally, the narcotic logs indicated there were two pills (Tylenol) taped into the resident's card of Percocet, but another pill was missing so there were three missing Percocet pills.

Law enforcement records indicated the AP gave her keys to the medication cart to a different staff member during her shift for approximately four minutes, however the report indicated camera images showed the staff member did not access the medication cart.

During consultation with law enforcement, video images did not show any other staff members enter the AP's medication cart. Law enforcement observed images of the AP taping "pills" into the medication card. The AP told law enforcement she taped pills into medication cards but denied taking the Percocet tablets.

AP's employment records indicated the facility provided medication management education to her when they hired her and evaluated her performance with medication administration. This included narcotic medications.

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;

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No. Memory loss.
Family/Responsible Party interviewed: No. Declined interview.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility provided education to staff members regarding narcotic diversion.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35051	A. BUILDING: _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE	107 BRIDGEWATER WAY STILLWATER, MN 55082

(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 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: #HL350512261C/#HL350512741M On May 29, 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 fifty five residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL350512261C/#HL350512741M, 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. 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.	02360		

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02360	Continued From page 1 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. No plan of correction is required for this tag	02360		