DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL366291901M **Date Concluded:** March 15, 2023
Compliance #: HL366293528C

Name, Address, and County of Licensee Investigated:
Elysian Senior Homes of Duluth
110 Coffee Creek Boulevard
Duluth, MN, 55811
Saint Louis County

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

Evaluator's Name: Angela Vatalaro, 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), a staff member, financially exploited the resident when the AP took the resident's supply of Morphine (opioid pain medication).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. Camera footage showed the AP remove a narcotic medication card from the locked narcotic box in the medication cart. The AP put the medication card outside the narcotic area, folded the card, and then slid it into her pocket. There was a preponderance of evidence to support the medication removed was the resident's Morphine supply.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The AP did not respond to a subpoena for an interview. The investigator contacted law enforcement and reviewed the law enforcement report. The investigation

included review of the resident's medical records, incident reports, narcotic logs, facility internal investigation, staff schedules, camera footage, the AP's personnel file, facility policies related to medication management, narcotics, and maltreatment. Also, the investigator observed the facility's narcotic count and medication storage system.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident was oriented to self. The resident's medication management assessment indicated the resident was unable to safely store controlled medications and controlled medications were double locked in a medication cart accessible to staff assigned to the resident.

The resident's incident report indicated, during an overnight shift, a staff member went to administer the resident's morphine medication. The resident's supply was not in the narcotic locked box in the medication cart.

The resident's shift report records indicated the resident had a "really rough night" without all her comfort medications due to no supply because the medication went missing. The resident did not sleep.

The resident's prescriber orders indicated the resident had orders for Morphine 15 mg (milligrams) take one-half tablet by mouth every four hours as needed for pain or shortness of breath. The resident's medication administration records, narcotic count and medication log indicated the evening before the morphine went missing, the resident had a dose of morphine at 8:29 p.m. with 47 tablets left.

The facility internal investigation indicated leadership received a report the resident was experiencing pain and a staff member went to retrieve the resident's morphine from the medication cart. At 11:30 p.m. the morphine card was missing. The staff member searched the medication cart and was unable to locate the morphine card. The staff member reported the missing medication to a nurse. Leadership conducted a search for the medication; the medication was not found. The last dose of morphine was given the evening before at 8:29 p.m. Leadership interviewed all staff who worked between 8:29 p.m., the evening before through 11:30 p.m., the following day. All staff reported they did not give the medication and were unaware it went missing. The facility contacted law enforcement.

Staff schedules indicated the AP was scheduled a day shift in the resident's unit the same day the morphine reported missing. The AP's timecard indicated the AP punched in at 6:00 a.m., and punched out at 2:06 p.m.

The facility internal investigation notes and camera footage showed the day the Morphine went missing, the AP was at the medication cart at 9:42 a.m. The AP flipped the narcotic medication card into a straight position. The AP shuffled items in the medication cart drawer and pushed

her hand all the way down into the drawer. At 9:43 a.m. the AP had a folded medication card in her right hand while looking left. The AP switched the card from her right hand to the left and put the medication card that was in her left hand into her pocket.

The law enforcement report indicated camera footage showed the AP remove several medication cards out of the narcotic locked box and placed one card into the general prescription area to the left of the locked box. At 9:43 a.m., the AP pulled the card from the left side of the drawer and put the card into her pocket.

The AP's personnel file indicated the AP received competency training for medication administration including administering narcotics.

During an interview, leadership stated during internal investigation she watched camera footage from the time the resident received her last dose of morphine until the time staff reported it missing. Camera footage showed the AP remove a narcotic medication card from the locked narcotic box in the medication cart. The AP put the medication card outside the narcotic area, folded the card, and then slid it into her pocket. Leadership stated during the internal investigation the resident's Morphine was the only medication not accounted for.

During an interview, the registered nurse (RN) stated the resident was in pain when staff reported the resident's Morphine medication missing. The RN stated the AP received training on medication administration and trained on narcotics. The RN stated she watched the camera footage and saw the AP put the narcotic medication card into her pocket. She stated the resident's Morphine was the only narcotic not accounted for.

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. The resident was deceased.
Family/Responsible Party interviewed: No, declined to interview.
Alleged Perpetrator interviewed: No, did not respond to subpoena.

Action taken by facility:

The facility conducted an internal investigation, contacted law enforcement, and implemented a narcotic count between shifts. The AP is no longer employed by the facility.

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
Saint Louis County Attorney
Duluth City Attorney
Duluth Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36629	A. BUILDING: ______ B. WING ______	C 01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELYSIAN SENIOR HOMES OF DULUTH	**110 COFFEE CREEK BOULEVARD DULUTH, MN 55811**

(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 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: #HL366293528C/#HL366291901M On January 25, 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 36 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL366293528C/#HL366291901M, tag identification 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE

Minnesota Department of Health

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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 residents reviewed (R1) was free from maltreatment. R1 was financially exploited. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual staff person 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 (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	