Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL393449465M
Compliance #: HL393447264C

Date Concluded: March 11, 2024

Name, Address, and County of Licensee Investigated:
Suite Living Senior Care of Lakeville
20949 Keokuk Ave. 23
Lakeville, MN 55044
Dakota County

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

Evaluator's Name:
Maerin Renee, 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 the AP stole morphine (narcotic pain medication) from the resident's personal supply.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. Based on a preponderance of evidence, the AP took the residents morphine for her own personal use.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and family. The investigation included review of the resident records, death record, pharmacy records, the facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement reports, and related facility policy and procedures. Also, the investigator observed staff interactions with residents in the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease and failure to thrive. The resident's service plan included assistance with medication management, and activities of daily living. The resident's assessment indicated the resident was not oriented to person, place, or time; was vulnerable to abuse and exploitation, and the resident would not be able to report abuse, neglect, or exploitation.

The resident's medication administration record (MAR) indicated the resident was prescribed as-needed (PRN) morphine for pain management. At a later point, an order for scheduled morphine was prescribed to supplement the residents pain medication regimen. The pharmacy delivered the card of scheduled morphine to the facility.

The facility's internal investigation indicated staff notified the on-call nurse that a card of the resident's morphine tablets was missing. A staff member said on the evening shift the previous day, pharmacy delivered a card of morphine which the staff numbered it, documented it in the narcotic logbook, and placed the morphine in the lockbox of the medication cart. She later completed the narcotic medication count with the oncoming overnight staff and the count was accurate at that time. The same staff member came in the next day for another evening shift and completed the narcotic medication count with the outgoing day staff member. The evening staff member asked about the morphine she had logged in the evening before, and the day staff said she was not aware morphine had been delivered for the resident. The staff members noticed the narcotic logbook had been partially whited out, written over with information for haloperidol (haloperidol is not a narcotic medication and would not need to be counted with the narcotic medications), and the medication card for haloperidol had been placed in the narcotic medication lockbox. With the medication card for morphine replaced with the card of haloperidol, and the narcotic logbook page whited out and written over with haloperidol, the day staff member had not known the morphine was missing when she completed the morning medication count with the overnight staff member.

The facility internal investigation indicated facility leadership viewed camera footage, and the overnight staff member was removed from the schedule pending results of the investigation.

Three video clips were provided by the facility. Review of the first video clip indicated the AP standing at medication cart. An open book was set in front of the AP (identified by staff as the narcotic logbook). The AP had a blanket over her head. The AP was hunched over the narcotic logbook and appeared to be writing in it. The AP then stood up, and something could be seen in her hands. She appeared to screw something together with both hands and then placed the item in her pocket. The AP removed her right hand from her pocket and took a pen from the top of the medication cart. The AP then reached into the medication cart with her right hand and closed the narcotic logbook with her left hand. The AP took the narcotic logbook in her left hand, searched in the medication cart with her right hand and then withdrew a medication card. The AP then walked around to the desk behind the medication cart and began to sit down.

In the second video clip, the AP was sitting at the desk with the open narcotic logbook in front of her. The AP had the medication card in her right hand. The blanket over her head somewhat obscured her actions. The AP transferred the medication card into her left hand and started to write something in the narcotic logbook with a pen.

The final video clip cut ahead. The narcotic logbook was closed. The AP stood up with the narcotic logbook in her hands. The medication card the AP had brought around to the desk could not be seen. The AP stood up and walked back around to the medication cart. The AP was holding the narcotic logbook in her right hand, but she did not have the medication card she had removed from the medication cart. The AP placed the narcotic logbook in the medication cart. The AP dug around the medication cart before picking up another medication card and reading it. The video then ended.

Review of the police report indicated the AP was charged with 609.52.2(a)(1) Theft-Take/Use/Transfer Movable Prop-No Consent, a misdemeanor. The property taken was identified as 30 tablets of 5mg morphine sulfate.

Review of the AP's background check history indicated the AP had been disqualified from providing direct contact services or having access to people who receive services due to three convictions of Misdemeanor Theft-Take/Use/Transfer Movable Prop-No Consent in three different counties over three years.

When interviewed, a nurse said she received a report that an entire medication card of morphine was missing. Staff informed her it appeared the narcotic logbook had been altered. It appeared morphine had been whited out and haloperidol had been written over it. Haloperidol is not a narcotic medication and would not need to be logged and counted. Staff reported that medication counts for the other narcotic medications in the medication cart were accurate. Staff reviewed camera footage. The nurse said the overnight staff member appeared in the frame, wearing a blanket over her head. The nurse observed the AP opening the medication card, and the narcotic drawer. The nurse said the morphine came from their pharmacy, and the bubble packs are orange. She could tell the color of the card was orange, which would have been the morphine. The nurse said she could see the AP doing something in the narcotic book but could not tell where the card of morphine went. The pharmacy confirmed the morphine had been delivered. The day staff member who counted narcotic medications with the overnight staff did not notice the haloperidol was not a narcotic, so the discrepancy was not caught during the morning medication count. During the afternoon count, the afternoon staff member, who had accepted the morphine the evening before, noticed the morphine was missing and her entry in the narcotic logbook had been whited out and written over. As part of the internal investigation, the nurse contacted the AP and asked the AP why she had placed haloperidol in the narcotic lockbox, and why she documented it on a page in the narcotic logbook that already had a medication written on it. The AP said she did not do that, and then said she could not recall. The nurse said the AP's story changed multiple times.

When interviewed, the afternoon staff member said she had accepted a delivery of the resident's morphine, put it in the narcotic box in the medication cart and logged it into the narcotic logbook. The afternoon staff member said she completed the narcotic medication count with the oncoming night staff member. At that time the count was correct, and all narcotic medications were accounted for. She left for the night and returned the next afternoon. She initiated the narcotic medication count with the outgoing day staff member and noticed the page in the narcotic logbook in which she had documented the morphine delivery had been whited out and written over with haloperidol. The afternoon staff member said during the morning medication count, the day staff member did not realize haloperidol is not a narcotic, so the haloperidol was counted as if it was a narcotic medication, and the discrepancy was missed. Both staff members reported the discrepancy to nursing.

When interviewed, the AP denied taking the residents morphine.

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: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation, updated the narcotic medication policies, and retrained staff in the management of narcotic medications. 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
Dakota County Attorney
Lakeville City Attorney
Lakeville Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39344	A. BUILDING: _____ B. WING _____	C 02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF LAKEVILLE LLC	20949 KEOKUK AVENUE LAKEVILLE, MN 55044

(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: #HL393447264C/#HL393449465M On February 20, 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 13 residents receiving services under the provider's provisional Assisted Living with Dementia Care license. The following correction order is issued for #HL393447264C/#HL393449465M, 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 resident reviewed (R1) was free from maltreatment. 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.	02360	No plan of correction is required for this tag.	