Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL397769385M
Compliance #: HL397767122C

Date Concluded: May 3, 2024

Name, Address, and County of Licensee Investigated:
St Charles Assisted Living
402 W 4th Street
St Charles, MN 55972
Winona County

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

Evaluator's Name: Julie Serbus, 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 multiple residents when the AP signed out narcotic pain medications for three residents on hospice but failed to administer the medications.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP, who was an unlicensed caregiver, was observed setting up medications at a medication cart she was not assigned to and was asked to stop. Afterwards, narcotic medications from three residents signed out by the AP were found to be missing.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a contracted agency. The investigator also contacted family members. The investigation included review of medical

records, progress notes, service plans, medication administration records, staff schedules, facility policies and procedures, and the law enforcement report. The investigator made an onsite visit to the facility and observed medication administration process along with process for double-locked narcotics.

A facility investigation indicated one afternoon the AP, who was not scheduled to work, was in the memory care unit and was observed at the medication cart setting up medications for multiple residents to be administered later that shift. An unlicensed caregiver approached the AP and asked the AP to stop doing this. The AP complied and left the area but returned a brief time later and went to the locked medication cart. Once the AP left the unit again, the unlicensed staff who had been observing her went to the cart and found medications set up in medication cups to be administered later that day. A review of the narcotic book indicated the AP had signed out four tablets of hydromorphone and initialed the blister packs indicating she had punched out the four doses of the narcotic from three separate residents. The unlicensed staff checked resident #1, resident #2, and resident #3 for the narcotic and found the hydromorphone (a narcotic) was missing from each respective medication cup.

All three residents resided in an assisted living memory care unit and were on hospice care.

Resident #1
Resident #1 diagnoses included Lewy Body Dementia (type of dementia associated with excess deposits in the brain) and coronary artery disease (narrowing of the hearts major blood vessels). The resident's service plan included medication administration. The resident's assessment indicated the resident was at risk of being abused by others due to dementia and impaired judgment.

Resident #1 had an order for a scheduled narcotic later in the shift. The blister pack for the narcotic showed a punched out one narcotic tablet with the AP's initials. The narcotic book page for this same medication indicated the AP removed the narcotic from resident #1's supply and documented it to be give later in the evening on the same day (6 pm).

Review of resident #1's medication administration record indicated the narcotic was scheduled to be given later that day. Resident #1's medication administration record indicated another staff member had initialed off on the medication administration record that they had administered the medication.

Resident #2
Resident #2 diagnoses included dementia and a decline in health due to a recent hip fracture. The resident's service plan included medication administration. The resident's assessment included disorientated to person, place, and time.

Resident #2 had an order for an "as needed" narcotic medication. The blister pack for the narcotic showed two narcotic tablets punched out with the AP's initials. The narcotic book page

also indicated two narcotic tablets had been removed from resident #2's supply with the AP's initials for later the same day (2 pm and 6 pm). The electronic medication administration record (EMAR) indicated an entry under the AP's computer log-in showing a narcotic administered at 2:00 p.m. and a follow up note entered seven minutes later indicating resident #2's pain was "improving".

The second "as needed" narcotic that was punched out from the blister pack and signed out by the AP in the narcotic book to be given at an exact time by another staff member later in the shift. The second tablet was not listed as administered later in that shift and the additional dose that had been punched out was not found in a medication cup.

Resident #3

Resident #3 diagnoses included metastatic cholangiocarcinoma (bile duct cancer) with metastatic (spread of cancer) to the liver and lymph nodes, and dementia. The resident's service plan included medication administration. The resident's assessment indicated disorientated to place and time.

Resident #3 had an order for as needed narcotic medication. The blister pack for the narcotic showed one narcotic tablet punch out with the AP's initials. The narcotic book page indicated one narcotic tablet had been removed with the AP's initials and to be given later in the evening (8 pm).

The AP

A review of the AP's time punches in payroll indicated she was on the timeclock for approximately 45 minutes that morning although she was not in the afternoon or evening on that same day.

During an interview, the AP stated she was not on the schedule but had come to the facility with her dog to show another coworker. The AP stated this co-worker asked the AP to help with setting up medications in the memory care unit. The AP stated she was told to punch in and the AP stated she did punch in. The AP stated she was in the memory care unit for about an hour but stated she needed to leave at a certain time as she had a prior obligation and asked the unlicensed staff member to punch her out.

Interviews:

During an interview, unlicensed caregiver #1 stated she observed AP enter the memory care unit on a day the AP was not scheduled to work, then saw the AP setting up medications for residents for the afternoon shift so she approached the AP and asked her to stop because she was not on the schedule nor punched in. Caregiver #1 stated she told the AP should not set up medications to be administered later for another caregiver. Caregiver #1 stated the AP left the unit briefly but returned, went back to the medication cart, and then left the unit a second time. Caregiver #1 looked in the medication cart and found medication cups with medications set up for resident #1, #2, and #3. She also checked the narcotic book and found entries

indicating AP had signed out narcotics for these same residents, but none of the pre-setup medications cups contained narcotics. Caregiver #1 stated each unit as has a caregiver assigned and designated to setup and administer medications for that shift. That designated caregiver is the one who should punch out the medication, administer the medication, and document it as given. Caregiver #1 stated medication is not allowed to be set up ahead of time as that was not the policy, and it was a medication error waiting to happen.

During an interview unlicensed caregiver #2, who was working on the assisted living side of the facility on the day of the incident, stated the AP stopped by the facility after lunch to show staff members her dog. Caregiver #2 stated the did not ask the AP to punch in or to set up medication in the memory care unit.

During an interview, a manager, who is also a nurse, stated staff punch members punch in and out of by using their fingerprint image and if staff missed a punch, they would need to fill out a missed punch form. Only a manager can manually enter a missed punched time. The manager stated there were inconsistencies with between the EMAR and the times the AP signed off medications.

In conclusion, the Minnesota Department of Health determined financial exploitation was substantiated.

Substantiated: Minnesota Statues, 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 Statues, 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 service for the profit or advantage of another.

Vulnerable Adult interviewed: Residents deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:

The facility called law enforcement. Facility purchased new medication carts. Only the delegated medication person has a set of keys on their person during the shift and the second set of keys is with the facility administration person. The AP is no longer employed at 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
Winona County Attorney
St Charles City Attorney
St Charles Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39776	A. BUILDING: _____ B. WING _____	C 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CHARLES ASSISTED LIVING	402 WEST 4TH STREET SAINT CHARLES, MN 55972

(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: #HL397767122C/#HL397769385M On April 9, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued: 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, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 1 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 three of three resident(s) 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.	