*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL348754003M
**Compliance #:** HL348756696C

**Date Concluded:** February 16, 2023

**Name, Address, and County of Licensee Investigated:**
Talamore Senior Living St. Cloud
215 37th Avenue North
St. Cloud, MN 56303
Stearns County

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

**Evaluator's Name:** Jill Hagen, RN, Special Investigator

**Finding: Inconclusive**

**Nature of Visit:**
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 facility staff, financially exploited Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, and Resident #7, when the AP took the residents narcotic medication for personal use.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined financial exploitation was inconclusive. Facility staff reported the AP indicated she administered Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6 narcotic medication when the staff knew the residents were actually asleep. The AP denied the allegation and stated the residents were still in bed when they took their narcotic medications that morning. Resident #1's Morphine (opioid pain medication) reconciliation (medication count completed by two staff at the end and beginning of a shift) indicated two tablets were unaccounted for, however, the AP stated the last time she reconciled the Morphine there were no missing tablets. The AP stated she administered

Resident #7’s discontinued Tramadol (opioid narcotic pain medication) because the resident was complaining of pain that morning.

The investigator conducted interviews with facility staff including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident’s medical record, medication administration record, narcotic logs, facility staff schedules, and policies and procedures including medication management and narcotic medication reconciliation. Also, the investigator observed the security of the medication room, medication cart, the narcotic storage, and medication reconciliation process.

Resident #1, #2, #3, #4, #5, #6, and #7 resided in an assisted living memory care unit. All residents required staff assistance with medication management including medication set-up and administration.

Resident #1’s provider prescription included Morphine 5 milligrams (mg) one capsule dissolve in the mouth every four hours as needed for pain.

Resident #2’s provider prescription included Lorazepam (anti-anxiety) 0.5 mg one capsule every four hours as needed for anxiety/agitation.

Resident #3’s provider prescription included Morphine 5 mg dissolve in the mouth every four hours as needed for pain.

Resident #4’s provider prescription included Morphine 5mg dissolve in the mouth every four hours as need for pain and/or dyspnea (shortness of breath) and Lorazepam 0.5 mg ½ tablet every four hours as needed for anxiety.

Resident #5’s provider prescription included Tramadol (opioid analgesic) 50 mg ½ tablet every four hours as needed for pain.

Resident #6’s provider prescriptions included Morphine 5mg dissolve in the mouth every four hours as needed for pain.

Resident #7’s discontinued provider prescription included Tramadol 50 mg ½ tablet two times a day and as needed for pain.

Review of the facility investigation indicated one morning an unlicensed staff member reported to facility management the AP was altering the narcotic logbook during medication reconciliation the beginning of the shift.  The staff member stated the AP dispensed Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6 their as needed pain and/or anxiety medications when the residents were still asleep. Management met with the AP and requested the AP turn in the keys for the medication cart and narcotic medication storage. The AP provided no explanation to management for dispensing the as needed medications to the

residents. During further investigation by management, additional concerns included Resident #1 had two missing Morphine tablets from the bubble pack (sealed compartment for medications) and Resident #7 had one Tramadol missing from the discontinued bubble pack of medications. Facility staff assessed the residents following the allegation and none of the residents experienced increased pain or anxiety.

During an interview, the unlicensed staff member stated the AP provided medication administration on the day shift and the staff member provided the care to the residents. The staff member stated that morning the AP counted the narcotic medications with a staff from the previous shift. The staff stated she became “suspicious” of the AP because she was frequently in the medication cart and narcotic logbook. When the AP took a break that morning the staff checked the resident’s medication administration records. The staff stated the AP documented administering anxiety and/or pain medications to Resident #2, #3, #4, #5, and #6, when the residents were still sleeping. In addition, Resident #1 had two unaccounted for Morphine tablets and Resident #7 was missing a Tramadol from the discontinued bubble pack.

During an interview, management stated they reviewed the narcotic logbooks for the residents after the AP left the building. Management stated when the ULP’s dispense as needed medications, there was no requirement for the ULP’s to notify the nurse of the administration. When requested, management could not provide evidence the AP was responsible for Resident #1’s two missing Morphine tablets.

During an interview, the AP stated she was responsible for the residents’ medication administration on the memory care unit on the day of the incident. The AP reconciled the narcotic medications at the beginning of the shift with another staff without issues. The AP stated she was not aware the narcotic medication count was off for Resident #1’s Morphine tablets. The AP stated Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6 were awake when she gave them their narcotic medications. The AP stated she dispensed the discontinued Tramadol to Resident #7 because the resident complained of pain that morning. The AP stated she was aware a discontinued medication should not be dispensed to a resident but thought the mediation would help Resident #7’s pain. The AP stated the Tramadol was not on Resident #7’s medication administration record therefore the AP failed to document and account for the administration of the medication.

There was no active police investigation into the allegation.

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

**Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.**
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

**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 profitor 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**: Attempted Resident #1, Resident #5, and Resident #6 but unable to provide information due to cognition.
**Family/Responsible Party interviewed**: Yes for Resident #1, Resident #2, Resident #5 and attempted Resident #3, Resident #4, Resident #6, and Resident #7's family members.
**Alleged Perpetrator interviewed**: Yes

**Action taken by facility:**
Management provided all staff training on their vulnerable adult policy and procedure, training to medication administration staff about the narcotic count and passing as needed medications. Management moved the overstock narcotic medications from the medication cart to the nurse office, and an electronic narcotic count system was implemented. The AP is no longer employed by the facility.

**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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34875 | A. BUILDING: _____ B. WING _____ | C 12/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TALAMORE SENIOR LIVING | 215 37H AVENUE NORTH SAINT CLOUD, MN 56303 |

| (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<br><br>On December 28, 2022, the Minnesota Department of Health initiated an investigation of complaint # HL348756696C/#HL348754003M. No correction orders are issued. | 0 000 | | |