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

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL296474683M
**Compliance #:** HL296477967C

**Date Concluded:** April 26, 2023

**Name, Address, and County of Licensee Investigated:**
The Waters of Edina
6300 Colonial Way
Edina, MN 55436
Hennepin County

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

**Evaluator's Name:** Brooke Anderson, RN
Special Investigator

**Finding:** Inconclusive

**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 facility nurse, financially exploited Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6 when the AP took the residents' narcotic medications for personal use.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined financial exploitation was inconclusive. Due to conflicting information and lack of orientation provided by the facility, it is unable to be determined if the AP destroyed the narcotic medications or if the AP took the narcotics for personal use. There were no witnesses to the incidents.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident medical records, personnel files, and facility policies and procedures. At the time of the onsite visit, the investigator toured the facility and observed interactions between staff and residents.

Resident #1 resided in an assisted living facility. The resident's diagnoses included chronic pain, and major depressive disorder. The resident's service plan included assistance with medication management. The resident's assessment indicated the resident had mild cognitive impairment; occasionally needing redirection and reassurance.

Resident #2 resided in an assisted living memory care unit. The resident's diagnoses included osteoporosis, osteoarthritis, and pain. The resident's service plan included the resident received assistance with bathing, dressing, and medication management. The resident's assessment indicated the resident had mild cognitive impairment.

Resident #3 resided in an assisted living facility. The resident's diagnoses included colon cancer, schizoaffective disorders, and bipolar disorder. The resident's service plan included behavior monitoring and medication management. The resident's assessment indicated the resident needed frequent reassurance and redirection.

Resident #4 resided in an assisted living facility memory care unit. The resident's diagnoses included dementia. The resident's service plan included but was not limited to bathing, dressing, and medication management. The resident's assessment indicated the resident had short-term memory impairment.

Resident #5 resided in an assisted living facility memory care unit. The resident's diagnoses included dementia, depression, and arthritis. The resident's service plan included reassurance checks and medication management. The resident's assessment indicated the resident was orientated to self. The resident was enrolled in Hospice care.

Resident #6 resided in an assisted living facility. The resident's diagnoses included depression and osteoarthritis. The resident's service plan included medication management. The resident's assessments indicated the resident was cognitively intact.

Review of the facility investigation indicated facility staff reported suspicious entries made over the course of two months in the narcotic logbook.  Entries made by the AP lacked documentation of destruction of narcotics and failed to include initials or signatures of second nurse authorization.

Resident #1's narcotic logbook indicated the AP documented hydrocodone (opioid analgesic) 5-325 milligrams (mg) was "wasted pill bubble pack was open" and "pulled by mistake." Resident #1 was not in the facility at the time indicated on the entry.

Resident #2's narcotic logbook indicated the AP documented oxycodone (opioid analgesic) 2.5mg was "wasted-grabbed for wrong resident" and "2 disposed d/t broken seal."

Resident #3's narcotic logbook indicated the AP documented two entries of oxycodone 5mg "wasted due to accidently pulling twice-wasted."

Resident #4's narcotic logbook indicated the AP documented lorazepam (anti-anxiety medication) 0.5mg was given. No documentation in the resident's medication administration record indicated the lorazepam was administered.

Resident #5's narcotic logbook indicated the AP documented tramadol (opioid analgesic) 50mg was "wasted-order d/c'd [discontinued]."

Resident #6's oxycodone 5mg was discontinued. Another facility nurse had prepared fourteen pills, along with paperwork for destruction of resident #6's oxycodone medication. That facility nurse and the AP did not destroy the medications as planned. The facility nurse left the medications locked in the medication cart. After completion of the AP's shift that day, the oxycodone was not found in the locked medication cart and no additional paperwork had been completed to indicate it had been destroyed.

Review of the facility investigation identified the AP did not appropriately or consistently document medication administration and/or medication destruction. Medication destruction lacked the witness and signature of a second nurse to verify the entry and destruction of the medication.

During an interview, the AP stated she had not received training on narcotic destruction. The AP said the facility needed her on the floor and said she would receive the eight hours of training at a different time. The AP stated her training consisted of shadowing another nurse for two shifts. The AP denied taking the narcotics for personnel use and stated she looked in the narcotic logbook at how other nurses completed the narcotic destruction. The AP stated she placed the narcotics in the med safe (a device used to destroy medications) but did not have another witness with her to verify her actions. The AP said she did not contact the facility on-call nurse for assistance but did admit there was a nurse on-call that could have educated her on the process.

Review of the AP's personnel file indicated the AP was not trained in narcotic destruction.

During investigative interviews, multiple staff members indicated the pattern of discrepancies in the narcotic logbook were not normal for the facility. Staff stated the process of narcotic destruction consisted of two nurses counting the narcotics, documenting in the narcotic logbook with two sets of initials, and filling out a medication destruction form with the signatures of both nurses. Both nurses were required to witness the narcotics being placed in the med safe. Staff further indicated medication destruction forms were not completed for the narcotic destruction of resident #1, resident #2, resident #3, resident #5 and resident #6. Staff stated they did not witness the AP destroying medications in the med safe.

During an interview, resident #6 stated she did not feel any medications were taken for personal use by the AP. Resident #6 stated it was probably a lack of supervision or training and the AP not knowing the protocol.
During interviews, the family members of resident #1, resident #3, and resident #6 stated they had no concerns with the care provided at the facility.

No police investigation was initiated regarding this incident.

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 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**: Resident #2 and Resident 6.
Resident #1, Resident #3, Resident #4, and Resident #5 were not available for interview.
**Family/Responsible Party interviewed**: Resident #1, Resident #3, and Resident #6.
Attempts to contact families of Resident #2, Resident #4, and Resident #5 were not successful.
**Alleged Perpetrator interviewed**: Yes

**Action taken by facility:**
The facility completed an internal investigation and provided re-education on the process of medication destruction to all staff. The AP is no longer employed at the facility.

**Action taken by the Minnesota Department of Health:**
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

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 |
|---|---|---|---|
| | 29647 | A. BUILDING: _____ B. WING _____ | C 03/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE WATERS OF EDINA | 6300 COLONIAL WAY EDINA, MN 55436 |

| (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>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL296477967C/#HL296474683M<br><br>On March 23, 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 72 residents receiving services under the provider's Assisted Living with Dementia Care license.<br><br>The following correction orders are issued for #HL296477967C/#HL296474683M, tag identification 1470. | 0 000 | Assisted Living Provider 144G.<br><br>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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS | |

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| 0 000 | Continued From page 1 | 0 000 | USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 01470 SS=D | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>(9) a review of the types of assisted living services the employee will be providing and the | 01470 | | |

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| 01470 | Continued From page 2<br><br>facility's category of licensure.<br>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of four employees (licensed practical nurse/LPN-C) with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). | 01470 | | |

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| 01470 | Continued From page 3<br>The findings include:<br><br>LPN-C was hired on November 10, 2022, to provide direct care to the residents and supervise the staff.<br><br>LPN-C's employee record did not include the following required orientation content:<br>- an overview of the 144 G statutes<br>- an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person<br>- handling of emergencies and use of emergency services<br>- compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC)<br>- the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person<br>- handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints<br>- consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>- a review of the types of assisted living services the employee will be providing and the facility's category of licensure<br><br>The investigator received an email April 3, 2023, at 2:28 p.m. from licensed assisted living director (LALD)-B that stated all documentation from | 01470 | | |

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| 01470 | Continued From page 4<br><br>LPN-C's employee file was provided. The facility was unable to locate additional forms.<br><br>The licensee's Orientation and Annual Training Requirements Policy dated April 2021, noted all team members must complete the orientation to Assisted Living requirements before providing Assisted Living services to residents.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01470 | | |