Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL313347865M
Compliance #: HL313344721C

Date Concluded: January 16, 2024

Name, Address, and County of Licensee Investigated:
Stoney River Ramsey
14401 Nowthen Boulevard NW
Ramsey, Minnesota 55303
Anoka County

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

Evaluator's Name: Nicole Myslicki, 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) financially exploited a resident when two 30-day supplies of narcotic medications went missing after the AP received them from the pharmacy.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was inconclusive. The facility never recovered the controlled substances, and the AP denied taking the controlled substances although she signed for them during a medication delivery. Additionally, multiple staff stated the facility did not have a set protocol for receiving medications from the pharmacy at the time of the incident, and all nursing staff had access to the medication rooms.

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident's medical record, facility information including policies related to the allegation,

and incident reports. Also, the investigator observed medication rooms, as well as controlled substance storage and logs.

The resident resided in an assisted living facility. The resident's diagnoses included cancer and chronic pain. The resident's service plan included assistance with medication management.

The resident admitted to the facility on hospice. The resident's admission orders included lorazepam 0.5 milligrams (mg) by mouth every four hours as needed for agitation, restlessness, anxiety, or shortness of breath, and hydromorphone 1 mg by mouth every four hours as needed for pain or shortness of breath.

The resident's medical record included progress notes indicating the resident would not receive medication administration the day of admission.

A pharmacy delivery receipt indicated the AP signed for 30 tablets of lorazepam and 30 tablets of hydromorphone.

During an interview, the AP stated she did not take the resident's controlled substances. That evening, the AP signed the pharmacy invoice receipt and accepted medications for facility residents from the pharmacy delivery driver. She did not review the medications to ensure the pharmacy invoices matched which the delivered medications. The AP brought the medications back to the medication room of her unit and left the bags there while she completed tasks and assisted residents. Later when the evening slowed down, the AP brought the medication bags to the appropriate units throughout the building. The AP delivered the resident's bag of medications to the appropriate medication room and informed the unlicensed personnel (ULP 1) passing medications for that unit. At no point during the shift did the AP open any of the medication bags. The AP stated although the medication rooms were secured with codes, all nurses and aides had access to the rooms.

During an interview, ULP 1 stated all the nursing staff had access to the medication rooms. Throughout ULP 1's time at the facility, there had been many nursing and management changes. At the time of the incident, staff did not have clear direction for medication deliveries, so unlicensed staff would often just receive the medications, look to see who the medications were for, then place the bag in the appropriate medication cart or medication room until a nurse arrived to take care of the medications. During the middle of a medication pass, the pharmacy delivery driver arrived. ULP 1 witnessed the AP receiving medications. Later in the shift, ULP 1 found a medication bag on the medication cart she had been working out of. ULP 1 left the bag in the medication cart since the facility had not started administering medications to the resident yet. During shift change the next morning, ULP 1 informed ULP 2 about the medication bag.

During an interview, ULP 2 stated she started her shift the next morning and received report from ULP 1 who reported there had been a medication delivery the night before, and the bag

was on the table in the medication room. ULP 2 completed her morning medication pass, then brought the bag to the nurse to open together. The nurse then realized the controlled substances, lorazepam and hydromorphone, were supposed to be in the delivery. ULP 2 stated the facility did not teach her how to accept medications from the pharmacy delivery driver until after this incident occurred.

During an interview, a nurse stated it had not been uncommon during that time for staff to leave delivered medications for the nurses the next day, but it was her first time seeing it occur for delivered controlled substances. The nurse stated they completed an investigation after opening the medication bag and not finding the hydromorphone. The nurse stated there had been a second bag containing the lorazepam, but the hydromorphone was missing. They checked throughout the facility, including in the medication carts and resident apartments but did not recover the controlled substance. The facility completed an in-service training with staff regarding the proper protocol for controlled substances.

During an interview, a family member stated they had extra medication from prior to the resident's admission they were able to administer the resident until the new medications arrived, so she did not have to go without medication.

During an onsite visit, the investigator observed the facility's controlled substances were stored according to their policy. Additionally, staff accurately verbalized the current pharmacy delivery process which included only accepting medications after staff have compared the pharmacy receipt and delivered medications to ensure all medications were delivered. Then staff deliver medications to each appropriate medication cart, and enter controlled substances into the narcotic book before placing them in the narcotic box.

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;

Vulnerable Adult interviewed: No; The resident is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility completed an internal investigation and training with staff. Additionally, 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
	31334	A. BUILDING: _____ B. WING _____	C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEY RIVER RAMSEY	14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303

(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 On December 20, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL313344721C/#HL313347865M. No correction orders are issued.	0 000		