Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52446925M
Compliance #: H52441442C

Date Concluded: March 5, 2025

Name, Address, and County of Licensee Investigated:
Long Prairie Healthcare Center
20 Ninth Street SE
Long Prairie, MN 56347
Todd County

Facility Type: Nursing Home

Evaluator's Name:
Jana Wegener, 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 resident was financially exploited by drug diversion when the alleged perpetrator, AP, facility nurse, took the residents-controlled drug pain medication (Tramadol) for her own use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation by drug diversion was inconclusive. Although 1 of the resident's Tramadol pills was unaccounted for following the AP's shift, the resident reported his pain was managed. The resident record indicated the AP had a pattern of numerous documentation errors, and controlled drug counting discrepancies. The AP had made similar errors in the past involving 3 other residents, but determined no diversion occurred for those residents. It could not be determined if the resident's missing Tramadol pill was the result of an error or if financial exploitation occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record(s),

pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, police report, police body camera footage, related facility policy and procedures, and previous federal investigation documentation.

The resident resided in a skilled nursing facility with diagnoses including Multiple Sclerosis (a progressive neurologic condition), muscle spasms, and chronic pain.

The resident's assessment and care plan indicated he received medication administration services from the facility. The assessment and care plan indicated the resident had chronic pain that was well managed using scheduled and as needed (PRN) pain medications including Tramadol 50 milligrams (mg) every 8 hours, scheduled to be given at bedtime and twice daily PRN for a maximum of 3doses (150 mg) daily.

A facility medication error report indicated another staff identified and reported a discrepancy with the resident's Tramadol and indicated the AP had logged an additional duplicate date and time entry for the resident's bedtime Tramadol. The entry did not align with the administration documented in the resident's medication administration record (MAR).

A review of the resident's MARs in comparison to the narcotic logs showed the AP had documentation omissions and repeatedly failed to accurately document the remaining Tramadol count on the MAR. Due to a lack of accurate documentation by the AP causing discrepancies in the counts it could not be determined if diversion or errors in documentation occurred.

- The resident's Tramadol narcotic log identified the AP had 6 discrepancies in the narcotic log verses the count on the MAR, and indicated the AP failed to document the administration of Tramadol on the resident's MAR.
- The resident's October MAR Tramadol count indicated the AP had discrepancies of 5 Tramadol tablets unaccounted for. However, the narcotic log did not reflect that any Tramadol was missing
- The resident's November MAR Tramadol count indicated the AP had discrepancies of 15 Tramadol tablets unaccounted for. However, the narcotic log failed to indicate any other Tramadol was unaccounted for in November.

A facility investigation identified 3 other resident's had similar errors including administering the wrong medication, wrong dose, and routinely failed to document the administration of controlled drug narcotic pain medications on the residents MAR's. The facility investigation identified the resident's reported they had received their medications with no concerns of diversion identified. The facility investigation did not identify any other count discrepancies or possible diversion of the resident's Tramadol.

Interviews with facility licensed and unlicensed staff indicated at change of shift when the resident's Tramadol count was noted to be off the AP appeared to be under the influence by behaving strange/off, unable to focus/distracted, could not find her medication cart keys, had

to be redirected back to complete the change of shift counts repeatedly which was not normal behavior for the AP. However, other staff interviewed indicated they had no concerns regarding the AP under the influence while at work. Staff stated the MAR and narcotic log counts should always match and indicated any discrepancy between the 2 would indicate possible diversion and should be reported.

When interviewed facility leadership stated after the resident's Tramadol was reported missing the facility investigated to determine if any other possible diversion could have occurred. Leadership stated the investigation included an audit of all residents who received controlled drugs which identified the AP had other medication errors and documentation discrepancies involving 3 other residents, but no diversion occurred for those residents. Leadership stated the AP documented giving 3 doses of Tramadol to the resident on her shift, one of which was a duplicate entry added during change of shift counts with oncoming staff after the count was found to be off. Leadership stated staff witnessed the AP add a duplicate entry to make the count correct. Leadership staff stated when the AP was asked about the missing Tramadol pill she became defensive and was unable to explain where the pill went. Leadership stated the resident reported receiving his Tramadol with no unrelieved pain, but denied getting the duplicate dose of Tramadol as documented by the AP.

During email communication this investigator provided the aforementioned discrepancies between the resident's MAR and narcotic log counts from October and November and requested to review the findings with leadership. Although the facility investigation failed to identify the other Tramadol count discrepancies by the AP in October and November, the facility failed to respond or provide an explanation for the discrepancies. As a result, it could not be determined if ongoing diversion or errors in documentation had occurred.

A police report and body camera footage indicated the AP appeared to be under the influence when questioned by law enforcement about the resident's missing Tramadol later that evening. The police report indicated leadership staff and law enforcement observed the AP had slurred speech, dilated pupils, bloodshot watery eyes, and struggled to respond appropriately to questions in a way that made sense. The police report indicated the AP had and odor of alcohol when officers were in close proximity and indicated the AP showed signs of intoxication while at work. The police report indicated the AP denied drinking while at work or doing drugs. The police report indicated when the AP was asked to complete a breathalyzer test to show she was not under the influence, she refused. The police body camera footage showed the AP was unable to follow or respond appropriately to questions. After officers asked the AP if she was under the influence of anything she made excuses for her behavior/appearance and stated she was "called in and tired as hell", then told an officer she, "may have left the med cart open and someone else took the resident's Tramadol".

An undated written statement signed by the AP indicated she had completed and corrected the count at change of shift with oncoming staff. The statement failed to indicate the AP denied or admitted to diverting the resident's missing Tramadol.

In conclusion, the Minnesota Department of Health determined financial exploitation by drug diversion 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: No declined
Family/Responsible Party interviewed: N/A
Alleged Perpetrator interviewed: Refused to respond to interview attempts.

Action taken by facility:
The facility reported potential diversion to the Minnesota Adult Abuse Reporting Center (MAARC) and law enforcement. The facility suspended the AP and investigated the possible diversion. The facility provided education to identify, prevent, and report possible diversion to all staff. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility compliance. 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.

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

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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
	00778	A. BUILDING: _____ B. WING _____	C 02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG PRAIRIE HEALTH CARE CENTER	20 9TH STREET SE LONG PRAIRIE, MN 56347

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H52446925M/#H52441442C, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000	The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		