Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H5358018M
Compliance #: H5358014C, H5358015C, H5358016C, H5358017C

Date Concluded: January 12, 2022

Name, Address, and County of Licensee Investigated:
Hilltop Health Care Center
410 Luella Street
Watkins, MN 55389
Meeker County

Facility Type: Nursing Home

Evaluator's Name: Carrie Euerle MSN, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit: An unannounced visit was conducted to investigate 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.

Allegation(s): Financial exploitation occurred when a licensed nurse (alleged perpetrator/AP) took resident narcotic medication for his/her own personal use.

Investigative Findings and Conclusion:
Financial exploitation was substantiated. The alleged perpetrator (AP) was responsible for the maltreatment. The AP admitted to the facility and police that s/he took narcotic medication for his/her own use despite the facility having policies and procedures in place to prevent narcotic diversion.

The investigation included interviews with facility staff members, including corporate, administrative, and nursing staff. In addition, the investigator contacted residents and families of residents involved in the incident.

Facility staff initially discovered discrepancies in a resident's (Resident #1) narcotic log, medication administration record and physician orders which led to investigation and identification of narcotic diversion by the AP.

Resident #1 had a signed physician's order for oxycodone (a narcotic pain medication) five milligrams (mg) to be given orally as needed (prn) every four hours for pain rated 3-6, and 10 mg for pain rated 7-10, using a scale of 1-10.

Upon interview, Resident #1 denied taking any recent oxycodone, as s/he was currently on a plan to taper off the medication.

Review of Resident #1's medication administration record and narcotic log identified a nurse (alleged perpetrator/AP) as the individual who had been signing out the narcotic medication during the time which the resident indicated s/he had not received the medication.

Upon identifying this, the AP was questioned by administrative staff and admitted to taking five to ten tablets of Resident #1's narcotic medications. The AP was then immediately terminated by the facility.

The facility reported the above incident and then began a further investigation; upon full review of all narcotic count logs, medication administration records and physician orders of residents, three other residents (Resident #2, #3 and #4) were also identified as having discrepancies in their records. All residents included in the incident had prescribed as-needed (PRN) oxycodone medication. The narcotic log and medication administration records and documentation of the AP for administration of the Oxycodone medication was further compared to the AP's timecard, revealing discrepancies in times allegedly administered and the times the AP was working in the facility.

Resident #2's physician orders included Oxycodone five mg tablets, every six hours as needed for moderate to severe pain. Resident #2 had multiple narcotic log discrepancies. It was discovered that on multiple occasions, the AP was documenting administration of medication in the narcotic log and did not enter it in the medication administration record. There was a total of 21 tablets that had not been documented in the medication record and the narcotic log included duplicated dates and times for the scheduled PRN doses. In addition, the times and dates of documented medication did not match up with the AP's timecard.

Resident #3 had physician orders for oxycodone five mg to be administered every three hours as needed for severe pain. Resident #3's narcotic log and medication record, as compared to the AP's timecard, included multiple discrepancies.

Resident #4 had physician orders for oxycodone five mg to be administered as needed twice daily for moderate to severe pain. Resident #4's narcotic log and administration record, including as compared to the AP's timecard, included multiple discrepancies. Resident #4 had

documentation of excessive PRN administration of the oxycodone in the narcotic log when the AP was working. The entry also included dates and times which were no accurate, and multiple paper documentation entries that did not coincide with medication administration record. Twenty-four tablets of Oxycodone were documented as administered in the narcotic log but not documented administered or wasted on the medication administration record.

Resident #1, Resident #2, and the family of Resident #4 were interviewed. No resident or family could recall pain or harm due to the medication not being administered. The family of Resident #3 could not be reached for interview.

During an interview, a detective from local law enforcement told surveyors that when the AP was interviewed by law enforcement, she admitted taking five to ten tablets of oxycodone from the facility.

In conclusion, financial exploitation was substantiated. Although the AP did not respond to requests for interview, the AP admitted to the facility and to police that s/he diverted oxycodone from Resident #1. Further investigation identified three additional residents, all who had physician orders for as-needed (PRN) oxycodone, with the medications having been signed out by the AP with discrepancies identified within the narcotic log, medication administration records, and/or the AP's timecard. It is more likely than not the AP also diverted oxycodone from these additional residents.

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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: AP did not return requests for interview

Action taken by facility:
The facility reported, investigated the incident, and terminated the AP's employment.

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

http://www.health.state.mn.us/divs/fpc/directory/surveyapp/provcompselect.cfm, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
Meeker County Attorney
Watkins City Attorney
Meeker County Sheriff's Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00798	A. BUILDING: _____ B. WING _____	C 01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP CARE CENTER	410 LUELLA STREET WATKINS, MN 55389

(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 #H5358018M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	2 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the	

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2 000	Continued From page 1 #H5358018M, tag identification 1850. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000	far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the evaluators findings are the Suggested Method of Correction and 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/RULES.	
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional	21850		1/31/22

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21850	Continued From page 2 distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure four of four residents reviewed (R1, R2, R3, R4) were free from maltreatment. The residents were financially exploited by a staff member who diverted narcotic medication. Findings include: On January 12, 2022, the Minnesota Department of Health (MDH) issued a determination that financial exploitation occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	21850	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the far left column entitled "ID Prefix Tag. " The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by. " Following the investigators ' 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	

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21850	Continued From page 3	21850	STATUTES/RULES. Corrected	