Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H5411113M

Date Concluded: February 16, 2022

Name, Address, and County of Licensee Investigated:
Shirley Chapman Sholom Home East
740 Kay Avenue
St. Paul, Minnesota, 55102
Ramsey County

Facility Type: Nursing Home

Evaluator's Name: Danyell Eccleston, RN, Special Investigator

Finding: Substantiated, individual responsibility

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.

Allegation(s): It is alleged: The alleged perpetrator (AP), a licensed practical nurse (LPN), financially exploited residents when she stole narcotic medications from 8 residents and falsified documentation regarding narcotic disposal for 1 resident.

Investigative Findings and Conclusion:
Financial exploitation was substantiated. The AP was responsible for the maltreatment. Over an eleven-month period the AP failed to document the administration of 946 doses of narcotic medications and falsified disposal documentation of nine narcotic patches. The AP was in a manager role that included conducting medication audits and educating staff about medication documentation and destruction processes.

The investigation included interviews with facility staff members, including administrative staff, nursing staff. The residents' medical records, narcotic logbooks, employee training and history, and facility policy and procedures were reviewed. In addition, the residents' family members and the police were contacted.

Resident #1's medical record indicated diagnoses including multiple malignancies and a healing fracture. Resident #1's provider pain medication orders indicated oxycodone as needed every three hours and hydrocodone-acetaminophen as needed every four hours. Comparison of Resident #1's narcotic record and medication administration record over a one-month period indicated the AP failed to document the administration of six doses of oxycodone and six doses of hydrocodone-acetaminophen after removing the medication from the medication cart.

Resident #2's medical record indicated diagnoses including chronic kidney disease and heart disease. Resident #2s provider medication orders indicated an order for tramadol four times daily as needed for pain. Comparison of Resident #2s narcotic record and medication administration record over a six-month period indicated the AP failed to document the administration of 157 doses of tramadol after removing the medication from the medication cart.

Resident #3's medical record indicated diagnoses including multiple malignancies and a fracture. Resident #3's provider medication orders indicated he had an order for oxycodone every three hours as needed for pain. Comparison of Resident #3's narcotic record and medication administration record over a one-month period indicated the AP failed to document the administration of six doses of oxycodone after removing the medication from the medication cart.

Resident #4's medical record indicated diagnoses including kidney and heart disease. Resident #4's provider medication orders indicated oxycodone every six hours as needed for pain. Comparison of Resident #4's narcotic record and medication administration record over a three-month period indicated the AP failed to document the administration of 26 doses of oxycodone after removing the medication from the medication cart.

Resident #5's medical record indicated diagnoses including osteoporosis and a fracture. Resident #5's provider medication orders indicated oxycodone every six hours as needed for pain. Comparison of Resident #5's narcotic record and medication administration record over a two-month period indicated the AP failed to document the administration of 30 doses of oxycodone after removing the medication from the medication cart.

Resident #6's medical record indicated diagnoses including dementia and Parkinson's disease. Resident #6's provider medication orders indicated oxycodone every hour as needed for pain. Comparison of Resident #6's narcotic record and medication administration record over a seven-month period indicated the AP failed to document the administration of 185 doses of oxycodone after removing the medication from the medication cart.

Resident #7's medical record indicated diagnoses including chronic pain, multiple malignancies, and osteoarthritis. Resident #7's provider medication orders indicated oxycodone every two hours as needed for pain. Comparison of Resident #7's narcotic record and medication administration record over an eleven-month period indicated the AP failed to document the

administration of 221 doses of oxycodone after removing the medication from the medication cart.

Resident #8's medical record indicated diagnoses including kidney disease and joint pain. Resident #8's provider medication orders indicated oxycodone two times daily as needed and three times daily as needed for pain. Comparison of Resident #8's narcotic record and medication administration record over an eleven-month period indicated the AP failed to document the administration of 309 doses of oxycodone after removing the medication from the medication cart.

Resident #9's medical record indicated diagnoses including emphysema and chronic pain. Resident #9's provider medication orders indicated fentanyl patches to be applied every three days. Review of the Certificate of Inventory and Destruction of Controlled Substances indicated the AP documented the destruction of nine of Resident #9's fentanyl patches and review of the Disposition of Fentanyl Patches, which included the statement "Upon removal of a patch, flush via sewer system and a nurse and another staff member sign as a witness to disposal", indicated the AP and licensed practical nurse destroyed nine patches belonging to Resident #9.

During an interview, the AP stated she did not document as needed narcotic administrations because she worked on busy units, had other tasks to complete, and her work was demanding during the COVID-19 pandemic. The AP stated she thought half of the as needed narcotic medications were not documented in the medication administration record the past year but stated she did not remember how long she had been omitting the documentation. Part of the AP's role was to educate other staff members regarding medication documentation and administration processes. The AP stated her personal actions did not follow facility policy and she did not report issues with completing documentation to her superiors. The AP stated narcotic counts were conducted at the beginning of each shift with two staff members comparing documentation in the narcotic logbook and medication cart supply, however, that does not include reviewing the medication administration record documentation. The AP stated she did not always follow facility policy of having another nurse witness destruction of narcotics because previous Nurse Manager (NM)-N did not have her witness the destruction of narcotics, however, the AP stated there was one time she disposed of a resident's fentanyl patches and this was witnessed by another nurse.

During an interview, NM-N stated two staff members were always needed to witness the disposal of narcotics. NM-N stated she always had another staff member witness when she was disposing of narcotics and denied teaching staff members that it was appropriate to dispose of narcotics without a witness. NM-N stated documentation of narcotic administration involved signing out the narcotic and documenting the administration in the resident's electronic medication administration record.

During an interview, NM-P stated documenting removal of a narcotic in the narcotic log demonstrated a medication was checked out of the medication cart and the electronic

medication administration record documentation demonstrated the medication was given to the resident. NM-P stated being busy was not a valid excuse for staff members to not document in the electronic medication administration record. Documenting as needed pain medication in the electronic medication administration record was important because it created a prompt to follow-up with the resident to recheck pain levels and providers review the medication administration record when making care decisions for residents. NM-P stated she was looking for supplies in the nurse manager office and found a box of nine fentanyl patches that were prescribed to Resident #9 in an unlocked cupboard above the AP's desk. NM-P stated the patches should have been locked in the narcotic box and requested NM-H come to the cupboard and they both took the patches to the director of nursing.

During an interview, NM-H stated NM-P notified her when a box of fentanyl patches was found in the cupboard above the AP's desk. NM-H stated the patches had a resident name on them and she was shocked when the fentanyl patches were found in the cupboard. NM-H stated the patches should have been stored in the locked narcotic drawer and not an unlocked cupboard above the AP's desk. The medications should be destroyed when they are no longer in use.

During an interview, a licensed practical nurse stated the process for wasting narcotic medications was to have a witness during the destruction of the medication. The licensed practical nurse stated there was an instance when the AP requested that she sign a destruction of fentanyl patches for Resident #9 without witnessing the destruction. The licensed practical nurse signed the destruction sheet for the fentanyl patches because the AP was a trusted nurse manager, and she thought the AP was going to destroy the patches.

During the interview, the director of nursing stated narcotic audits were completed shift to shift between two staff members by reviewing the narcotic logs and physical count of narcotics, and review of the medication administration record was not part of the process. The director of nursing stated an eleven-month audit of the narcotic system indicated the AP failed to document 946 doses of narcotics, many of which involved oxycodone and tramadol. The director of nursing also stated a box containing nine fentanyl patches was found in the AP's office, however, the AP completed the narcotic destruction sheet for the patches which indicated the AP destroyed the patches. The director of nursing stated the AP had a significant amount of narcotic medication she did not document on as well as multiple occasions when the AP's signature was the only signature on the narcotic log.

During an interview, the administrator stated it was part of the AP's role to teach other nurses how to document medication administration and of the 20-30 nurses that worked at the facility, the AP was the only nurse found during a medication record audit to have ongoing issues not documenting narcotic administrations.

In conclusion, financial exploitation was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:
(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or
(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.
(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, multiple residents are deceased and other residents unable to communicate due to cognitive status
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: The facility conducted an internal investigation. The AP is no longer working at the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment. 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, 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
Ramsey County Attorney
Saint Paul City Attorney
Saint Paul Police Department
Drug Enforcement Administration
Minnesota Department of Human Services – Licensing
Minnesota Board of Examiners for Nursing Home Administrators
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00496	A. BUILDING: _____ B. WING _____	C 02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIRLEY CHAPMAN SHOLOM HOME EAST	740 KAY AVENUE SAINT PAUL, MN 55102

(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 #H5411113M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.	2 000		

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2 000	Continued From page 1 The following correction order is issued/orders are issued for #H5411113M, 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		
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 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	21850		2/22/22

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21850	Continued From page 2 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 interviews and document review, the licensee failed to ensure 9 of 9 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9) reviewed was free from maltreatment. R1, R2, R3, R4, R5, R6, R7, R8, and R9 were financially exploited. Findings include: On January 11, 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	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	