DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54143464M **Date Concluded:** November 21, 2023

Name, Address, and County of Licensee Investigated:
Viewcrest Health Center
3111 Church Place
Duluth, MN 55811
St Louis County

Facility Type: Nursing Home

Evaluator's Name: Carol Moroney RN, Special Investigator
Rhylee Gilb, 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 the resident when the AP signed out the resident's clonazepam (anti-anxiety medication) in the narcotic book but did not document the medication as given in the resident's electronic medication administration record on 13 occasions.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was inconclusive. Although the AP was the only staff to sign removal of clonazepam on the narcotic record, it could not be determined if the AP administered the medication or diverted it. The medication, which requires a written prescription, was ordered and delivered by the pharmacy to the facility, however there was not a transcribed order in the resident's medication administration record (MAR).

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator contacted the local police department. The investigation included review of the resident's records, facility narcotic ledger, the facility's internal investigation, the AP's personnel file, and the law enforcement report.

The resident resided in a nursing home. The resident's diagnoses included a right femur fracture. The resident admitted to the nursing home for short term rehabilitation with plan to discharge to her previous assisted living. The resident's service plan included assistance with bathing, activities of daily living, dressing, and with toileting. The resident's discharge nursing assessment from the previous skilled facility indicated the resident was alert and oriented.

The resident's progress notes indicated the resident resided at the facility for approximately one month. The previous skilled nursing facility discharge orders did not include an order for clonazepam. Subsequently, the facility did not have an order transcribed onto the MAR for clonazepam. A progress note on the day after admission, written by social services, indicated the resident wanted more medication to help her sleep as she had an order for melatonin (herbal sleep medication) to be used as needed. Social service staff wrote they updated the resident's nurse manager. There were no further progress notes about the resident's sleep for one month.

The narcotic ledger included a page count for clonazepam. The pharmacy label on the ledger indicated the order was filled on the second day of the resident's admission and was written for the facility. The quantity was 14 tablets. The AP removed the first dose on the same day the medication was delivered. The AP was the only nurse to remove doses of the clonazepam for a total of 13 doses over a month period of time.

The facility drug diversion policy indicated controlled substances would be counted every shift. The nurse or trained medication aid (TMA) going off duty would count the controlled substances compared to the narcotic ledger quantity with the oncoming nurse or TMA.

The facility staff did not identify there was a controlled medication logged into the narcotic ledger without an order in the MAR until the resident's discharge date.

Upon discharge, the nurse prepared medications to be sent home with the resident. At that time, the nurse discovered one remaining tablet of clonazepam without a physician order in the MAR. The nurse notified the director of nursing (DON). Email records indicated the DON found an older prescription for clonazepam was filled and sent to the facility without the facility receiving that physician order. The facility internal investigation found the AP had a significant pattern of removing controlled medications without signing the MAR as administered for several residents.

Review of the narcotic ledgers showed other than the resident's clonazepam, the AP was not the only staff person who removed controlled medications in other instances with other residents.

The facility internal investigation indicated when the DON interviewed the AP, the AP reported she gave the medication to the resident because she asked for it although there was not an order in her MAR to administer it.

The law enforcement report indicated the case was closed. Law enforcement responded to the allegation of a drug diversion at the facility. The facility reported their suspicions but indicated they were in the early stages of investigation and did not have direct evidence of the AP's diversion. Law enforcement closed the report and requested the facility to update them on the status of their investigation.

During an interview, a nurse stated she discovered the clonazepam medication at the resident's discharge but did not remember that being a medication the resident received. The nurse stated she reported the discrepancy to management. Regarding the AP, the nurse stated the AP did not appear under the influence of drugs at work and thought she was a good nurse.

During an interview, the AP stated the facility had put in a new computer system and staff were not properly trained on using it. The AP stated she administered the resident the anti-anxiety medication for lack of sleep. The AP stated at the time, the facility had a new DON and the DON accused her and other nurses of drug diversion.

The AP was interviewed and stated she did not take any medications. The AP stated one day the Director of Nursing told her she was under investigation and would be suspended until the investigation completion. The AP stated she said let me take a drug test or what ever you want. The AP stated the facility declined to administer a drug test. The AP said because of that she resigned. The AP stated she has not had any communication with the Board of Nursing or the local Police department. The AP said she has another position.

During an interview, the current DON stated she was not the DON at the time of the allegation.

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;
(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

Vulnerable Adult interviewed: No, the resident had moved to another facility.

Family/Responsible Party interviewed: Not applicable.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated the incident and reported to allegation to proper authorities. The facility re-educated all staff who administer medication regarding controlled substances policy, drug diversion policy, 8 rights of medication administration.

Action taken by the Minnesota Department of Health:
The facility was issued a federal deficiency and/or a state correction order for noncompliance with licensing requirements. For a copy of the Statement of Deficiencies, please call 651-201-4890.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	**3111 CHURCH STREET DULUTH, MN 55811**

(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	2 000		

*****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 H54143464M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed

Minnesota Department of Health

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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		