Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: H5502024M

Date Concluded: September 1, 2021

Name, Address, and County of Licensee Investigated:
Benedictine Care Community
201 9th Street West
Ada, MN 56510
Norman County

Facility Type: Nursing Home

Investigator's Name:
Maerin Renee, RN, Special Investigator

Finding: Inconclusive

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) financially exploited the client when she stole one hydrocodone tablet from the client.

Investigative Findings and Conclusion:
It was inconclusive whether financial exploitation occurred. Although one tablet of narcotic pain medication was unaccounted for, the resident, per documentation, stated she got confused about what medication she received on the day in question, and the AP denied taking the residents Oxycodone. A police report was filed, and no arrest was made.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted law enforcement. The residents medical record, staff training, medication system, facility policy and procedures, and the facility internal investigation was reviewed.

The resident's diagnoses included left hip pain and muscle weakness. The resident received services from the provider including staff assistance with activities of daily living (ADLs) and medication management.

One evening the resident requested a dose of her narcotic pain medication (Oxycodone), which was prescribed for twice a day. The nurse attempted to obtain the medication from the medication dispensing system (MDS) but discovered that two doses of the medication had already been removed for the resident that day so the MDS would not release the medication. The resident said she'd only received one dose of the medication that day, and the nurse contacted the Director of Nursing (DON) to investigate further.

During interview, the Director of Nursing (DON) stated the morning nurse stated she had dispensed a tablet of the pain medication around 10:00 a.m. that day and gave it to the AP to administer to the resident. The resident had received a dose of the medication at around 4:00 a.m., so this would have been her second dose. The AP told the DON she attempted to administer the medication to the resident, but the resident declined it. The AP stated she administered the Oxycodone to the resident at around 1:00 p.m. when the resident requested. The DON stated there was no documentation in the narcotic log, medication administration record (MAR), or progress notes the resident received the Oxycodone at 1:00 p.m. The DON said the AP would have been responsible for completing this documentation. During the process of the internal investigation the DON requested the AP complete a drug test on three separate occasions, but the AP declined. The DON described the AP as a good employee and an advocate for the residents.

During interview, the AP stated the resident first requested the narcotic pain medication at around 10:00 a.m. in the morning. The AP asked the nurse to sign it out of the MDS. When the AP received the Oxycodone, the resident said she was planning to go on a walk later and wanted to take the pain medication at that time. The AP said she wrote the resident's room number on the medication cup with the Oxycodone in and locked it up in the medication drawer. She then administered the medication to the resident at around 1:00 p.m. before the resident went on her walk. The AP stated staff were very busy that day and she did forget to document the administration of the Oxycodone to the resident. The AP stated she declined to take a drug test due to mental health factors exacerbated by the family tragedy and the medication she was prescribed. The AP denied taking the resident Oxycodone for her own personal use.

In conclusion, it was inconclusive whether financial exploitation occurred.

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.

Vulnerable Adult interviewed: Attempted, no response.

Family/Responsible Party interviewed: Attempted, no response.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation and reported the incident to the police.

Action taken by the Minnesota Department of Health:
No action taken at this time.

cc:
The Office of Ombudsman for Long-Term Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(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) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/5/21 and 5/6/21, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED; however no deficiencies were cited due to actions implemented by the facility prior to survey: H5502021C(MN72401) H5502022C (MN72347) The following complaint was found not to be substantiated: H5502023C (MN73209). 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, the facility must acknowledge receipt of the electronic documents.	F 000		

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

Electronically Signed | 05/12/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.