Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H55162911M **Date Concluded:** December 27, 2022

Name, Address, and County of Licensee Investigated:
Laurel Peak Health Care LLC
700 James Avenue
Mankato, MN 56001
Blue Earth County

Facility Type: Nursing Home

Evaluator's Name:
Jennifer Segal RN, Special Investigator
Jessica Sellner 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.

Initial Investigation Allegation(s):
The alleged perpetrator (AP), a facility staff, financially exploited a resident when the AP took 5 tablets of the resident's narcotic pain medication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP removed 5 tablets of Oxycodone (a narcotic) for the resident. However, the AP documented only administering 1 tablet of the Oxycodone to the resident. During the course of the investigation, additional narcotic medications for multiple residents were documented by the AP the narcotic medication was removed to administer, however, there was no corresponding documentation the narcotic had been administered to the resident. In addition, the AP had 2 prior incidents of financial exploitation

by drug diversion: thirteen years ago, and eight years ago. The AP's nursing license was reinstated without conditions approximately two years ago.

The investigation included interviews with facility staff members, including administrative and nursing staff. The investigation included a review of the resident's medical record, the facility narcotic logs, facility investigation, staff schedules, the AP's personnel file, and board of nursing previous actions on the AP's nursing license. The investigator contacted law enforcement and the resident representative.

The resident resided in a skilled nursing facility and required skilled nursing for wound care. The resident's narcotic pain medication included oxycodone (narcotic) every 12 hours as needed for pain.

The facility investigation indicated staff noted a discrepancy between the narcotic logbook and the resident's medication administration record. The facility narcotic logbook indicated the AP signed out 5 tablets of oxycodone to the resident within a seven-hour period. The AP recorded removing 1 tablet around dinner. Approximately five hours later the AP signed out 2 tablets of oxycodone for the resident. Two hours later the AP documented in the narcotic logbook removing another 2 tablets of oxycodone. The resident's medication administration record indicated the AP only administered one oxycodone to the resident, leaving 4 tablets of oxycodone removed but not administered to the resident. When the resident was interviewed, he stated he only received one oxycodone that evening around bedtime. The resident stated he never takes more than one tablet of oxycodone at a time and does not request another tablet until 12 hours passed since the last dose.

The facility investigation indicated after discovering the residents missing narcotic an audit was done for the residents who had current physician orders for narcotics. Multiple entries, with multiple residents, were identified of the AP removing narcotics but not administering them to the resident.

One of the residents reviewed indicated the resident had a physician order for hydrocodone (narcotic) every 6 hours as needed for pain. During review of one month the resident received a total of 59 hydrocodone across all shifts. The AP documented in the narcotic log removing 39 of the 59 tablets of hydrocodone over one month. Although the AP removed 39 hydrocodone, the AP documented on the medication administration record administering hydrocodone only 23 times. There were 16 doses of hydrocodone removed and not administered to the resident. When the resident was interviewed about his pain, he stated he had not had any changes in pain and he typically requests 1 tab in the morning, and 1 tab in the later evening, of hydrocodone.

Another resident reviewed indicated the resident's physician order directed for oxycodone every 6 hours as needed for pain. During review of one month the resident received a total of 44 doses of oxycodone across all shifts. The AP documented in the narcotic log removing 28 of

the 44 doses of oxycodone over one month. Although the AP removed 28 doses of oxycodone, the AP documented on the medication administration record administering oxycodone only 15 times. There were 13 doses of Oxycodone removed and not administered to the resident. When the resident was interviewed, he stated he generally requested Oxycodone one to two times per day.

Another resident identified during the investigation indicated the resident's physician order directed hydromorphone scheduled for twice daily and as needed. During review of twenty days the resident received a total of 47 doses of Hydromorphone across all shifts. The AP documented in the narcotic log removing 17 of the 47 doses over twenty days. Although the AP removed 17 doses of hydromorphone the AP documented administering hydromorphone on the medication administration record only 11 times. There were 6 doses of Hydromorphone removed and not administered to the resident.

Multiple staff were interviewed during the facility internal investigation with multiple concerns regarding the AP including discrepancy of medication documentation when the AP worked, the AP seemed forgetful, tired, and staff noticed recent, significant weight loss.

The police report indicated the facility reported an internal theft of resident medications. The resident's physician order directed to administer one oxycodone every 12 hours. According to the narcotic log, the AP administered a total of 5 tablets of oxycodone to the resident all within 7 hours. The facility noted a pattern of missed doses, uncharted doses, missing narcotics, and altered narcotic log entries that coincide with the AP's shift and handwritten log entries. Additional narcotic discrepancies were found through the course of the facility investigation which included the AP changing times on the narcotic log from previous staff entries, removing three doses of dilaudid from the narcotic log within a 45-minute timeframe, and documented administering PRN narcotics at atypical times and more often than other nursing staff. Overall, the AP stole the following narcotic medications: One resident had at least 5 dilaudid and 6 hydromorphone tablets stolen by the AP over a one-month period; Another resident was had at least 11 hydrocodone tablets stolen by the AP during a month review. Another resident had at least 5 lorazepam tablets and approximately 14 ml of liquid hydromorphone stolen by the AP during the two months reviewed. Another resident had approximately 6.5 ml of hydromorphone liquid stolen by the AP over 2 months; and another resident had at least 6 dilauded tablets stolen by the AP during the one month reviewed. The police report indicated the AP was interviewed and had multiple reasons for the narcotic discrepancy's including it could have been a technology error or the nurse who worked after her could have caused this. The police report indicated the AP had a prior conviction of theft and 5th degree possession of a controlled substance when the AP admitted to stealing oxycodone, dilaudid, and oxycontin from three different residents when previously working as a nurse caring for vulnerable adults.

The AP's nursing records from the MN board of nursing indicate the AP has a history of narcotic medication diversion with similar patterns of discrepancy in documentation. The board of nursing report indicated the AP admitted to prior drug diversion from vulnerable adults when

she documented taking 36 oxycodone from a resident but only administered 15 to the resident. The AP admitted taking at least three different residents' oxycodone in past and acknowledged other occasions that AP documented administering an as needed narcotic medication which was not requested by the residents and instead the AP used for herself.

When interviewed facility nursing administration stated when a resident is prescribed narcotic medication the nurse documents removing the narcotic medication on the narcotic log. When the narcotic medication is administered the resident, the nurse documents on the resident's medication administration record the date and time the narcotic was administered. They stated the night the residents 4 oxycodone went missing the AP was the only nurse on duty and the only person with key to storage room and the locked container where resident narcotics were stored.

In conclusion, the Minnesota Department of Health determined 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
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No, declined.

Action taken by facility:
The facility conducted an internal investigation, reviewed policies and procedures for administration of narcotic medication, and provided re-education to all staff regarding narcotic administration and documentation. The AP is no longer employed 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.

You may also call 651-201-4200 to receive a copy via mail or email
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
Blue Earth County Attorney
Mankato City Attorney
Mankato Police 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
	00035	A. BUILDING: _____ B. WING _____	C 10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELS PEAK CARE & REHABILITATION CE	700 JAMES AVENUE MANKATO, MN 56001

(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 #H55162911M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders	2 000		

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2 000	Continued From page 1 are issued for #H55162911M, 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 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.	21850		

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21850	Continued From page 2 This MN Requirement is not met as evidenced by: The facility failed to ensure 1 of 1 residents reviewed was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	21850	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	