Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: H5554021M

Date Concluded: November 10, 2020

Name, Address, and County of Licensee Investigated:
Renvilla Health Center
205 Elm Avenue
Renville, MN 56284
Renville County

Facility Type: Nursing Home

Investigator's Name: Shannan Stoltz, 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) financially exploited Resident #1 and Resident #2, when the AP signed out both Resident's controlled substance medications, but Residents claim they did not receive that medication.

Investigative Findings and Conclusion:
Financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP willfully used, withheld, or disposed of two Residents' controlled-substance medications when the AP checked out the medications from inventory, but did not administer the medications to either Resident. The AP removed a narcotic medication from Resident #1's inventory six times over the course of fourteen days. The AP also removed a narcotic medication from Resident #2's inventory 10 times over the course of thirteen days. There is a preponderance of evidence the AP diverted controlled substances from both Residents.

The investigation included interviews with facility staff members, including administrative staff and nursing staff. In addition, the investigation also included review of medical records, and review of facility policies and procedures.

Resident #1's medical record was reviewed. Resident #1's medical diagnoses included anxiety, vitamin deficiency, and high blood pressure. Resident #1's care plan indicated he received medication management, assistance of one with personal cares and dressing, and elimination monitoring.

Resident #1's Physicians Order Sheet indicated Resident #1's physician prescribed Tylenol #3 (acetaminophen-Codeine) 300-30 milligram (mg) tablets. The instructions notated to administer one to two Tylenol #3 tablets by mouth every four hours as needed for pain.

Resident's #1's Individual Narcotic Record indicated the AP removed Resident #1's Tylenol #3 from inventory a total of six times during a fourteen day period in 2019. This document also indicated that each separate removal by AP was for two Tylenol #3 tablets, which totaled 12 tablets. Removals were documented in military time: a Tuesday morning at 0215 hours, the next day (Wednesday) at 0106 hours, one week later (Wednesday) at 0020 hours, the next day (Thursday) at 0117 hours, the next day (Friday) at 0011 hours, and again four days later (Tuesday) at 0130 hours.

Resident #1's EMAR (electronic medication administration report) Monthly Report, for two different months in 2019, indicated Resident #1 did not receive any Tylenol #3 during these months.

Resident #1's General Nurse's Observations indicated a nurse conducted a pain interview with Resident #1, during which the resident denied having pain. This document also indicated the nurse performed cognition testing, which indicated Resident #1 might be experiencing cognitive impairment.

Resident #1's Progress Notes by Resident, indicated only one time that AP documented Resident #1 complained of pain, but does not indicate what AP did about the complaint of pain. This document has no other notations indicating additional complaints of pain, that AP administered Tylenol #3, nor that AP performed any follow up to ascertain the effectiveness of Tylenol #3.

Resident #2's medical record was reviewed. Resident #2's medical diagnoses included heart failure, cardiac pacemaker, and high blood pressure. Resident #2's care plan indicated she received medication set-up, assistance of one with personal cares and dressing, and cardiac disease monitoring.

Resident #2's Physicians' Order Sheet indicated Resident #2's physician prescribed Percocet (oxycodone-acetaminophen) 5-325mg tablets. Instructions indicated to administer one or two Percocet tablet(s) by mouth every six hours as needed for pain, document pain level prior to medication administration, and document follow-up information on whether medication relieved pain.

Resident #2's Individual Narcotic Record indicated the AP removed Resident #2's Percocet from inventory a total of ten times during a thirteen day period in 2019. This document also indicated that each separate removal by AP was for two Percocet tablets, which totaled 20 tablets. Removals were documented in military time: a Tuesday morning at 0425 hours, the next day (Wednesday) at 0330 hours, two days later (Friday) at 0130 hours, the next day (Saturday) at 0147 hours, and the day after that (Sunday) at 0203 hours. Removals occurred again three days later (Wednesday) at 0118 hours, the next day (Thursday) at 0150 hours, twice the following day (Friday) at 2330 hours and 0530 hours. The last removal occurred three days later (Monday) at 2315 hours.

Resident #2's EMAR Monthly Report, for two different months in 2019, indicated Resident #2 received Percocet tablets on three of the ten occasions that AP removed Percocet from Resident #1's inventory. This document does not indicate what occurred on the other seven times the AP withdrew Percocet from Resident #2's inventory.

An untitled internal investigation document from the facility indicated facility staff interviewed Resident #2. This document indicated, "{Resident #2} is cognitively intact and was interviewed regarding her pain management. {Resident #2} denied having any pain and stated 'I took it once when I first came and it bound me up, I didn't like

those pain medications'. {Resident #2} denied getting any pain medication over the past few weeks and stated 'I have been good.'"

A facility-provided document titled Summary of Investigation, undated, indicated that the several staff who took direct care of Resident's #1 and #2, had not witnessed any complaints of pain by either resident, and that it had been several weeks since either resident had complained of pain.

A facility-provided document titled General Nurse's Observations indicated a nurse conducted a pain interview with Resident #2. During this interview, Resident #2 stated she "uses ice packs and repositioning at night that help her instead of using PRN {pro re nata} pain medication", an icepack to the pelvic and hip areas are "effective for pain control." This document also indicated Resident #2 stated that in reference to her Percocet, she "does not need to take that as her pain is not bad anymore and does not want to have constipation issues."

A facility-provided document titled General Nurse's Observations indicated a nurse conducted a pain interview with Resident #2, whom denied having pain. This document indicated the director of nursing also interviewed Resident #2, whom denied having pain.

A facility-provided document titled Progress Notes by Resident, for two separate months, indicated the AP documented that Resident #2 complained of pain, but did not indicate what AP did about Resident #2's pain. These same documents did not include any notations that Resident #2 complained of pain, received any PRN Percocet, nor that a follow up for effectiveness of the Percocet occurred.

During an interview, the licensed practical nurse (LPN) whom first discovered the narcotic discrepancy stated Resident #1 never complained of pain, and did not take narcotics. The LPN also stated she had questioned direct-care staff about Resident #1's pain and staff had advised her that there had not been any complaint of pain, and that they had not brought forth any complaints of pain to a nurse. The LPN affirmed that the only place she found the narcotic removal from inventory was in the narcotic log. The narcotic was not signed off in the MAR, nor was it documented in the nursing notes, as was required by policy.

During an interview, the director of nursing (DON) stated an LPN brought forth suspicions that a drug diversion had occurred. The DON initiated an investigation, which found another drug diversion that involved a second resident. The DON's investigation included interviews with all staff that worked during the suspected drug diversions, to include an interview with the AP, who was the only staff member who reported that residents complained of pain. During the DON's investigation, the only documentation found of narcotic removal from inventory by the AP, was in the narcotic log. The AP had not documented the need for a narcotic pain reliever in either resident's nurse progress notes or MARs, as was required by policy. The DON suspended the AP. The DON also stated that she was not able to interview Resident #1 due to cognition issues. The DON did interview Resident #2, whom the DON reported as being cognitively sound and a good historian. According to the DON, Resident #2 stated that she had only took her prescribed narcotic for pain one time, when she first came to the facility, but had not taken the narcotic since. Resident #2 advised the DON she did not like the effect the narcotic had on her, currently did not have a lot of pain, and instead used non-narcotic therapeutics for pain relief. The resident also denied asking for or taking narcotic pain relief, during the several weeks the AP removed narcotics from inventory. During our interview, the DON verified the AP's signatures on the narcotic log, of all removed narcotic's, from both resident's inventory. The DON stated the facility reimbursed Resident #2 for the stolen narcotics, but Resident #1's family declined reimbursement.

During an interview, the power of attorney for Resident #1 stated he vaguely remembered the incident, but that he declined reimbursement from the facility for the diverted controlled substance medication.

The facility provided a document titled Licensed Practical Nurse (LPN) Position Description. This document required LPNs to adhere to company mission and core values, follow the Vulnerable Adult and Abuse Policy, and adhere to the Resident Bill of Rights. This document also indicated LPN's were to safely administer medications, as ordered by the physician. The AP signed this document at the beginning of her employment, acknowledging that she had read the job description and fully understood the requirements set forth by the document.

The facility also provided a document titled 2019 Employee Handbook contained company policies and procedures. The last page of the handbook required a signature which acknowledged receipt of the handbook, and that the signer had read and understood the contents. The AP signed this document at the beginning of her employment.

The facility provided document titled Student Transcript indicated the AP took the following courses: Abuse Prevention and Resident Rights, Clinical Competency in Medication and Pain Management, Elder Justice Act, Compliance and Ethics, Resident Rights, and Vulnerable Adults. Per this document, the AP completed these courses during the first week of her employment.

The facility provided document titled Controlled Substances (Medications/Narcotics) dated June 2017, indicated any controlled substance signed out for a resident, will also be signed out on the resident's EMAR.

The facility provided document titled Maltreatment Prohibition Policy, dated February 19, 2018, indicated, "MISAPPROPRIATION OF RESIDENT PROPERTY means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a VA's {Vulnerable Adult} belongings or money without the VA's consent. This also includes diversion of medications: a. 'Diversion of medications' is the transfer of a controlled substance or other medication from a lawful to an unlawful channel of distribution or use."

In conclusion, financial exploitation was substantiated.

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; both Residents were deceased.
Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: No; did not return phone calls.

Action taken by facility:
The AP was no longer employed by the facility. The facility replaced both Residents' medications.

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
Renville County Attorney
Renville City Attorney
Renville Police Department
Minnesota Board of Examiners for Nursing Home Administrators
Minnesota Board of Nursing, ATTN: Mary Squires