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 #: H5593036M
Compliance Report #: H5593037C

Date Concluded: December 22, 2021

Name, Address, and County of Licensee Investigated:
Good Samaritan Society
1000 South Second Street
St. James, MN, 56081
Watonwan 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 11 residents.

Investigative Findings and Conclusion:
Financial exploitation was substantiated. The AP was responsible for the maltreatment for resident #1 (R1), R2, R3, R4, R5, R6, R7, R8, R9, R10, and R11. After presented with video footage of her conduct, the AP admitted to taking narcotics from a resident's narcotic supply on one occasion. Review of resident records and narcotic logbook documentation revealed, on multiple occasions, the AP falsified resident narcotic record counts when transferring narcotic counts to new record sheets, failed to document administration of narcotics to residents, and documented changes to narcotic record counts with times she was not working and not assigned to care for residents.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, the residents' family members, and the AP. The investigator reviewed resident medical records, narcotic logbooks, and facility policies and procedures. In addition, the investigator contacted law enforcement and reviewed record and video footage of the AP.

Resident #1's medical record indicated she was admitted to the facility with diagnoses of impaired cognitive function, macular degeneration, glaucoma, chronic pain, muscle pain, and arthritis. Resident #1's provider medication orders indicated the resident had fentanyl patch and oxycodone prescriptions for pain. Resident #1's individual narcotic record indicated on three occasions the AP did not have a second staff member co-sign the disposal of Resident #1's fentanyl patch. Resident #1's narcotic record over a four-month time-period indicated the AP's documentation led to 13 fentanyl patches and 62 oxycodone pills unaccounted for. The AP documented these unaccounted-for narcotic medications on dates she was not working, that did not match how the medication was ordered, and when transferring narcotic counts to new record sheets.

Resident #2's medical record indicated she was admitted to the facility with diagnoses of osteoporosis with fractures, arthritis, anxiety, Alzheimer's disease, and stroke. Resident #2's provider medication orders indicated the resident had an oxycodone prescription for pain. Resident #2's narcotic record over a two-month time-period indicated the AP's documentation led to seven oxycodone pills unaccounted for. The AP documented these unaccounted-for narcotic medications with changes to narcotic record counts when transferring narcotic counts to new record sheets, and at times she was not working or assigned to care for the Resident #2.

Resident #3's medical record indicated she was admitted to the facility with diagnoses of multiple fractures, right shoulder pain, and muscle weakness. Resident #3's provider medication orders indicated Resident #3 had an oxycodone prescription for pain. Resident #3's narcotic record over a two-month time-period indicated the AP's documentation led to 18 oxycodone pills unaccounted for. The AP documented these unaccounted-for narcotic medications with narcotic record count changes at times she was not assigned to care for Resident #3 and changed narcotic record counts when transferring counts to new record sheets. The AP also did not document narcotic administration to Resident #3.

Resident #4's medical record indicated she was admitted to the facility with diagnoses of hip pain, joint pain, fractures, anxiety, depression, and lung disorder. Resident #4's provider medication orders indicated she had an oxycodone prescription for pain. Resident #4's narcotic record over a four-month time-period indicated the AP's documentation led to seven oxycodone pills unaccounted for. The AP did not document administration of these unaccounted-for narcotics or changes to narcotic record counts when transferring narcotic counts to new record sheets.

Resident #5's medical record indicated she was admitted to the facility with diagnosis of anxiety, hearing loss, cognitive impairment, neuropathy, and tremors. Resident #5's provider medication orders indicated Resident #5 had a hydrocodone-acetaminophen prescription for chronic pain. Resident #5's narcotic record over a one-month period indicated the AP's documentation led to five oxycodone pills unaccounted for. The AP did not document administration of the unaccounted-for narcotics Resident #5. The AP documented changes to narcotic record counts with times she was not working and changed narcotic record counts when transferring narcotic counts to new record sheets.

Resident #6's medical record indicated she was admitted to the facility with diagnoses of arthritis, fractures, cartilage softening, macular degeneration, and depression. Resident #6's provider medication orders indicated the resident had a tramadol prescription for pain. Resident #6's narcotic record over a one-month period indicated the AP's documentation led to seven tramadol pills unaccounted for. The AP documented changes to narcotic record counts when transferring narcotic counts to new record sheets.

Resident #7's medical record indicated he was admitted to the facility with diagnoses of dementia, lower leg ulcer, foot pain, and knee pain. Resident #7's provider medication orders indicated the resident had a tramadol prescription for pain. Resident #7's narcotic record over a two-month period indicated the AP's documentation led to six tramadol pills unaccounted for. The AP documented changes to narcotic record counts when transferring narcotic counts to new record sheets.

Resident #8's medical record indicated she was admitted to the facility with diagnoses of osteoporosis, fractures, chronic pain, Alzheimer's disease, neuropathy, schizoaffective disorder, and visual hallucinations. Resident #8 provider medication orders indicated the resident had tramadol prescriptions for schizoaffective disorder and hallucinations. Resident #8's narcotic record over a one-month period indicated the AP's documentation led to eight tramadol pills unaccounted for. The AP documented changes to narcotic record counts when transferring narcotic counts to new record sheets.

Resident #9's medical record indicated he was admitted to the facility with diagnoses of bipolar disorder, schizophrenia, fibromyalgia, depression, lung disease, neuropathy, and pressure ulcers. Resident #9 provider medication orders indicated the resident had a tramadol prescription for neuropathy. Resident #9's narcotic record over a one-month period indicated the AP's documentation led to six tramadol pills unaccounted for. The AP documented changes to narcotic record counts when transferring narcotic counts to new record sheets.

Resident #10's medical record indicated she was admitted to the facility with diagnoses of gout, dementia, anxiety, and muscle weakness. Resident #10's provider medication orders indicated Resident #10 had an oxycodone prescription for pain. Resident #10's narcotic record over a two-month period indicated the AP's documentation led to six oxycodone pills unaccounted for. The AP placed on oxycodone order for Resident #10 after the oxycodone was no longer needed. The

AP documented changes to narcotic record counts with times she was not working and at times she was not assigned to care for Resident #10.

Resident #11's medical record indicated she was admitted to the facility with diagnoses of neuropathy, arthritis, osteoporosis with fractures, chronic skin ulcers, glaucoma, and lung disease. Resident #11 provider medication orders indicated Resident #11 had a hydromorphone prescription for pain or difficulty breathing. Resident #11's narcotic record over a one-month period indicated the AP's documentation led to four hydromorphone pills unaccounted for. The AP did not document hydromorphone administration to Resident #11.

Medication cart video footage revealed the AP punching out multiple tablets from a medication pack that was taken out of the narcotic box.

The AP's employment file indicated she completed education regarding resident rights and "abuse and neglect pledge to protect."

A police report indicated the AP was arrested due to her diverting resident narcotics. Criminal charges with theft of prescription medication and neglect of vulnerable adults were recommended by law enforcement and forwarded to the county attorney's office.

During an interview, the AP stated she worked full-time at the facility primarily during the evening shift and would pick up additional shifts. The AP stated when administering narcotics to a resident, a staff member needed to sign the narcotic out in the narcotic book and document in the resident's medication administration record. The AP stated when a staff member needed to dispose of a pain patch that was removed from a resident, the staff member would need to keep the used patch until another staff member could witness the disposal and then both staff members would document the disposal. The AP stated at the start of a new shift the oncoming and off-going nurse would complete narcotic counts for each resident. The oncoming nurse would count the number of narcotics for the resident, the off-going nurse would hold the narcotic book, and both nurses would compare the number counted with the number written on the current narcotic sheet. During the facility investigation, the AP said facility management called her in before her shift to discuss the difference in numbers in the narcotic book. The AP stated management showed her the narcotic book where the numbers were different and stated that they had video footage of the time frame associated to the documentation they showed her. The AP stated she took the narcotics in the one instance. The AP declined to answer questions regarding what happened to the narcotics and if there were other instances when she took narcotics from residents.

During an interview, the interim director of nursing (DON) stated a registered nurse (RN) contacted her to say she found a miscount of eight oxycodone pills when reviewing pages of the narcotic logbook that was paperclipped together. The DON stated when she reviewed additional pages of the narcotic logbook, she noted occasions when the AP would start a new narcotic count sheet for a resident despite the page not being full. She also noted the AP would

transfer over a different number on the new narcotic sheet. The DON stated she, the administrator, and a human resources staff member met with the AP regarding the narcotic count discrepancies and that the AP could not explain the discrepancies. The DON continued to conduct an internal investigation and stated the facility's internal investigation found 13 fentanyl patch and 136 narcotic pill discrepancies attributed to the AP.

During an interview, an RN stated staff paperclip narcotic count pages together when a resident's narcotic count page gets full. The RN stated while conducting narcotic counts for Resident #3, the paperclip fell off and she noted some previous pages were not completely full and that narcotic counts from page to page did not match. The RN stated the documentation errors she saw were always completed by the AP.

During an interview, the administrator stated the DON called and informed her that there were narcotics missing at the facility. The administrator stated discrepancies were documented by the AP. The administrator said during the facility's internal investigation the AP was shown copies of a narcotic pill packet and documentation with narcotic count discrepancies. The administrator stated the AP denied taking the pills. The AP was informed by the DON that video footage of the incident was found and after the DON left the room, the AP only admitted to taking the pills in the instance and time frame that was on camera footage.

During an interview, Resident #7's family member stated, on occasion, Resident #7 would complain about being in more pain during the afternoon and evening. She stated she found this odd because the reports of pain were intermittent.

During an interview, Resident #10's family member stated about three months ago, Resident #10 started to experience increased breakthrough pain when she would visit which was in the evening after work. The family member did not know the cause of the pain and stated the pain "depended on the day."

In conclusion, financial exploitation was substantiated against the AP.

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, due to cognitive status and availability.
Family/Responsible Party interviewed: Yes, family members of 11 residents were interviewed.
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
Watonwan County Attorney
St. James City Attorney
St. James Police Department
Minnesota Department of Human Services – Licensing
Minnesota Board of Examiners for Nursing Home Administrators
Drug Enforcement Administration
Minnesota Board of Nursing

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00697	A. BUILDING: ______ B. WING ______	C 12/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	**1000 SOUTH SECOND STREET ST JAMES, MN 56081**

(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 #H5593036M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	2 000		

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2 000	Continued From page 1 #H5593036M, 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		12/22/21

Minnesota Department of Health

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21850	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the licensee failed to ensure 11 of 11 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11) reviewed was free from maltreatment. R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, and R11 were financially exploited. Findings include: On December 22, 2021, 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. Corrected.	