Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: H5636002M **Date Concluded:** January 13, 2020

Name, Address, and County of Licensee Investigated:
MN Veterans Home Fergus Falls
1821 North Park Street
Fergus Falls, MN 56537
Otter Tail County

Facility Type: Nursing Home

Investigator's Name: Jill Hagen, RN, PHN,
Special Investigator

Finding: Substantiated, facility and 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 several residents when she diverted narcotic medications.

Investigative Findings and Conclusion:
Financial exploitation was substantiated. The facility and the AP were responsible for the maltreatment. The AP took narcotic medications from separate units at the facility over approximately seven months. The AP told facility staff the medication was wasted and destroyed for various reasons. Facility staff co-signed for the destruction of the medication often not witnessing the actual wasting of the medication. That action provided the AP access to numerous resident medications. In addition, the AP took 14 of a resident's narcotic pain medication replacing the medication with Claritin, an allergy medication.

The investigation included interviews with facility staff members, including administrative staff and nursing staff, review of the residents medical records, narcotic log worksheets, medication destruction records and facility policies and procedures. In addition, the investigator contacted law enforcement.

The pharmacy delivered resident medications to the facility packaged in “bubble” pack cards with foil covering each individual dose. Only medications obtained during off-hours or on weekends came to the facility in medication bottles.

The facility had eight medication carts, each with a narcotic log book. Licensed staff entered all controlled medications into the log books with information including the resident name, strength of medication, and frequency. Staff double locked and stored the narcotic medications in the medication cart. The licensed nurse assigned to the cart maintained the security of the key to the cart. Three times a day, at the change of every shift, two licensed staff counted the narcotic medications, one using the log book, and one checking the number of narcotics that remained. Once the count was complete and accurate, both licensed staff signed the log book. For any discrepancies, staff completed a variance report and notified management. For any reason, when staff failed to provide a resident with a narcotic medication, the facility policy directed two staff to witness the destruction of the medication at the same time and sign to confirm the destruction.

One morning, a licensed nurse who worked two days consecutively on the same medication cart, prepared to give Resident #3 Modafinil, (Schedule IV controlled stimulant narcotic medication) 10 milligrams (MG) every day, noticed the narcotic count was altered. The previous day, there were 24 tablets remaining on the narcotic log. Someone wrote over the number four changing it to a three (23 not 24 tablets remained). The licensed nurse contacted the AP who had worked on the cart the previous evening. The AP requested the licensed nurse falsify documentation indicating she destroyed the medication. The AP said she would co-sign the destruction of the medication the following day. Instead, the licensed nurse reported the discrepancy to management. Management found two additional discrepancies with narcotic documentation by the AP from the same day.

During an interview with management, they said following the licensed nurse report of a narcotic medication count discrepancy, they conducted an investigation of the narcotic logs and reviewed video surveillance from a medication room for the previous evening. Through the investigation, management found the AP had 39 narcotic medication discrepancies involving 19 residents over seven months. The video showed the AP tampering with a resident’s bottle of Tramadol (narcotic pain medication). Management inspected the bottle and found the AP replaced 14 tablets of Tramadol with Claritin (an allergy medication) that was similar in size and shape to Tramadol. There was no evidence the AP harmed a resident with the drug diversion. The AP gave a resident medication when needed.

Management said the AP admitted to taking the narcotic medications but denied taking them out of the facility. The AP said she began diverting controlled medications about seven months prior to the facilities investigation. Resident #1 through Resident #19 all received controlled medications. The narcotic medications included Tramadol, Oxycodone, Hydrocodone,

morphine, and hydromorphone (Dilaudid) (all opioid narcotics), Lyrica (anticonvulsant controlled medication), and Clonazepam (sedative controlled medication).

Review of the 19 residents' medical records revealed the AP's drug diversion affected 15 of those residents. Review of the residents' narcotic logs revealed no other employee had a history of the number of controlled substances requiring destruction. The reasons provided by the AP included the medication fell on the floor, the resident refused the medication, the AP contaminated the medication in an unknown substance, and the AP removed the medication by accident. Also, facility staff failed to consistently observe the destruction of the medications, review the destruction sheets to ensure the AP destroyed the medications, and/or signed they witnessed the destruction at a later time. That practice allowed the AP to continue diverting controlled medications.

The facility reviewed and revised their policies and procedures involving narcotic medication counts and security of those medications. The facility provided staff education regarding the revised policies, ensuring staff observe the actual destruction of narcotic medication, and provide signatures following narcotic medication counts. Management completed audits of the narcotic log books and destruction sheets to ensure staff compliance. The facility no longer employed the AP.

Review of the police report revealed the AP admitted to taking 14 Tramadol tablets from one resident but denied ingesting the medication. The police forwarded their investigation for a summons for 5th degree theft.

The AP failed to respond for an interview through telephone calls and subpoenas.

In conclusion, exploitation by drug diversion was substantiated.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(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 Adults interviewed: No, Resident #1, #2, #3, #5, #7, #14, and #15 expired before the investigation.
Family/Responsible Party interviewed: Yes, able to contact Resident #6, #7, #9, #11, #13, #17, and #18's family member.
Alleged Perpetrator interviewed: No. The AP failed to respond to telephone messages and subpoenas.

Action taken by facility:

The facility reviewed and revised their policies and procedures involving narcotic medication counts and security of those medications. The facility provided staff education regarding the revised policies, ensuring staff observe the actual destruction of narcotic medication, and provide signatures following narcotic medication counts. Management completed audits of the narcotic log books and destruction sheets to ensure staff compliance. The facility no longer employed the AP.

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
Minnesota Board of Examiners for Nursing Home Administrators
Minnesota Board of Nursing
Minnesota Board of Pharmacy
Otter Tail County Attorney
Fergus Falls City Attorney
Fergus Falls Police Department
Drug Enforcement Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00531	A. BUILDING: _____ B. WING _____	C 12/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK FERGUS FALLS, MN 56537

(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 #H5636002M, 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	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the	

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2 000	Continued From page 1 #H5636002M, 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 "corrected" 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	far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN, WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
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	21850		

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21850	Continued From page 2 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. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure 15 of 19 residents (R1, R2, R3, R4, R5, R6, R7, R9, R10, R11, R13, R14, R15, R17, and R19) reviewed who received narcotic and/or controlled medications, were free from maltreatment. A licensed staff exploited the residents when she took their narcotic and controlled medications for her own use. Findings include: On January 13, 2020, the Minnesota Department of Health (MDH) issued a determination that financial exploitation occurred, and that the facility and individual staff person were 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		