Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: H5090060M **Date Concluded:** September 30, 2021

Name, Address, and County of Licensee Investigated:
Pleasant Manor LLC
27 Brand Avenue
Faribault, MN 55021
Rice County

Facility Type: Nursing Home

Investigator's Name: Angela Vatalaro, 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 diverted controlled medications.

Investigative Findings and Conclusion:
Financial exploitation was substantiated. The alleged perpetrator was responsible for the maltreatment. The AP said she dropped and wasted 19 tablets of resident 1's Adderall (controlled medication, stimulant) and flushed the tablets down the toilet without a second nurse witness. Registered nurse (RN)-A, the AP's co-signer, said he counted 10 tablets of Adderall and did not witness destruction. In addition, the AP removed two doses of resident 1's Adderall without orders, without a business reason, and the MAR (medication administration record) did not include documentation as administered. The AP removed two doses of Oxycodone (opioid) from the E-KIT (emergency supply of medications) for Resident 2 and the MAR did not include documentation as administered. The AP removed two tablets of Tramadol (opioid) and two tablets of hydrocodone/acetaminophen 5/325 mg (Lortab, opioid) from the E-

KIT for Resident 2 without orders, without a business reason, and the MAR did not include documentation as administered.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, resident 2, and the AP. The director of nursing at the time of the incident declined to interview. The investigator contacted law enforcement and reviewed law enforcement report. The investigation included a review of resident 1 and resident 2's medical records, narcotic records, pharmacy records, medication administration records, internal investigation, the AP's personnel file, and facility policies related to controlled medications and maltreatment.

Resident 1's medical diagnoses included multiple sclerosis, bipolar disorder, and attention-deficit hyperactivity disorder. Resident 1's Minimum Data Set (MDS) indicated difficulty focusing attention and disorganized thinking. Resident 1's care plan indicated she was independent with bed mobility, transfers, ambulated without a device, and received psychotropic medications as ordered.

Resident 1's Individual Narcotic Record indicated orders for d-amphetamine (Adderall) 30 mg two tablets by mouth three times daily. Resident 1's MAR indicated d-amphetamine scheduled three times daily at 9:00 a.m., 2:00 p.m., and 9:00 p.m.

Resident 1's narcotic records indicated one day the AP removed two 30 mg tablets of d-amphetamine at 5:00 p.m. That same day at 5:00 p.m., the AP removed a third 30 mg tablet and wrote a note indicating one tablet removed due to "drop/spit." The MAR indicated the AP administered 60 mg at 9:00 p.m. The next day, the AP removed two 30 mg tablets at 7:00 p.m., the MAR indicated the AP administered 60 mg at 9:00 p.m. That same day narcotic records indicated the AP removed two 30 mg tablets at 1:00 a.m. The MAR did not indicate the two 30 mg tablets the AP removed at 1:00 a.m., administered. A day later, the AP removed two 30 mg tablets at 7:00 p.m., and two 30 mg tablets at 8:30 p.m., the MAR indicated the AP administered 60 mg at 9:00 p.m. The day after that, narcotic records indicated the AP dropped and wasted 19 tablets of d-amphetamine and records included the AP's signature and RN-A's signature.

During interviews the AP and RN-A both stated the AP asked RN-A to count resident 1's Adderall tablets that dropped. During an interview RN-A said he went to the AP's medication cart and counted 10 tablets of dropped Adderall. He said they were unable to access the medication disposal bin that evening for destruction. He said the AP asked him to watch her flush the medications down the toilet, which was not policy, and told her to wait until the next day when they had access to the medication disposal bin. He said when he returned for his next shift the Adderall was gone. He said he wrote a statement. During an interview RN-B stated after RN-A returned to the unit he told her he counted 10 Adderall tablets with the AP to waste. Resident 1's narcotic records indicated 19 tablets of Adderall wasted. The administrator stated

during an interview the day after the Adderall tablets wasted a facility staff member brought the waste to leadership's attention and an investigation conducted.

The facility's internal investigation indicated the AP changed the quantity of Adderall dropped from 10 to 19 not in the presence of the AP's co-signer. The internal investigation indicated the facility asked the AP about the day 19 tablets of Adderall wasted. The AP said she tried to remove medications for resident 1, lost her balance, and knocked pills over. RN-A's written statement indicated he counted 10 tablets with the AP and did not witness destruction. The AP said nine tablets went into the medication cart drawer. The AP said she flushed the tablets and did not have another person present to witness because she was too busy. The investigation indicated the AP removed two doses of resident 1's Adderall without medical provider orders. The AP said the resident was anxious and wanted more Adderall. Resident 1 said the AP did not give them to her, so she removed additional doses and administered the medication. The AP said there was not a PRN (as needed) order for the additional Adderall. She said she did not communicate with the medical provider and administered the Adderall to resident 1 without orders. When the facility asked why the AP did not call the medical provider verses removing the medication, she said she was not sure. During the investigation the facility discovered the AP removed controlled medications for resident 2 from the E-KIT and records did not include evidence that all the medications administered.

Resident 2's medical diagnoses included aftercare following joint replacement surgery. Resident 2's Minimum Data Set (MDS) indicated she received PRN pain medications. Resident 2's care plan indicated she required assistance with dressing, bathing, transfers, and received pain medication as ordered.

Resident 2's Emergency Drug Kit Slip for Oxycodone 5 mg reviewed against resident 2's MAR indicated the AP removed Oxycodone 5 mg one tablet at 6:00 p.m., the MAR indicated the AP administered Oxycodone 5 mg at 5:45 p.m. The next day, the AP removed Oxycodone 5 mg one tablet at 6:00 p.m., the MAR did not include documentation as administered. A day later, the AP removed Oxycodone 5 mg one tablet at 6:00 p.m., the MAR did not include documentation as administered. That same day the AP removed Oxycodone 5 mg one tablet at 10:30 p.m., the MAR indicated the AP administered Oxycodone 5 mg at 10:25 p.m.

Resident 2's progress notes indicated the date resident 2 admitted to the facility. The same progress notes indicated eleven days after admission, the medical provider ordered Tramadol 50 mg twice daily as needed for pain. Resident 2's MAR indicated the dated orders for Tramadol 50 mg one tablet every 12 hours as needed for pain.

Resident 2's Emergency Drug Kit Slip indicated the AP removed Tramadol 50 mg two tablets from the E-Kit at 3:00 p.m., five days after Resident 2 admitted. Seven days later, the AP removed Tramadol 50 mg one tablet from the E-Kit at 9:50 p.m. The MAR did not include documentation as administered.

Resident 2's Individual Narcotic Record from the narcotic book reviewed against resident 2's MAR indicated the AP removed hydrocodone/acetaminophen 5/325 mg one tablet at 3:30 p.m., from the locked narcotic box in the medication cart. The MAR indicated the AP administered hydrocodone/acetaminophen 5/325 mg at 4:15 p.m. The Individual Narcotic Record indicated resident 2 had 25 tablets left after the AP removed the one tablet at 3:30 p.m. Resident 2's Emergency Drug Kit Slip indicated at 9:25 p.m., the AP removed hydrocodone/acetaminophen 5/325 mg two tablets from the E-KIT, the MAR did not include documentation as administered.

During an interview, the administrator stated the day after resident 1's Adderall was wasted a facility staff member brought it to leadership's attention and an investigation conducted. She stated upon record review the wasted Adderall quantity clearly appeared wrote over and the facility questioned that. She said she interviewed both the AP and the AP's co-signer. She said the purpose of a second nurse co-signer was to witness what controlled medications are wasted. She spoke to the AP about the day 19 tablets of Adderall wasted. The AP stated the quantity counted and wasted was 19. RN-A who co-signed as witness stated the quantity counted was 10 and he did not witness destruction. The AP said she flushed 19 tablets without a witness and said she did not follow facility policy. The administrator said the AP was asked about why she removed Adderall medication without orders, the AP said resident 1 was very anxious. The AP was asked why she did not call the medical provider for direction instead of removing the medications and the AP said she was not sure. The administrator said law enforcement was contacted regarding the incident and the facility continued with its internal investigation. She stated the facility also investigated the AP's involvement with resident 2's controlled medications.

During an interview, RN-A stated the AP asked him to count resident 1's Adderall that she dropped on the floor. He went to the AP's medication cart and counted 10 tablets of Adderall with the AP. He said they were unable to access the medication disposal bin that evening for destruction. The AP asked him to watch her flush the medications down the toilet which was not policy. RN-A said he stopped the AP from flushing the medications and recommended the AP keep the 10 tablets in the medication cart and include the wasted medications in the narcotic count until they could access the medication disposal bin the next day for proper destruction. The AP agreed. He counted 10 tablets not 19. When he worked his next shift, the Adderall was gone. He provided a written statement of the incident. He said facility policy for medication destruction was to use the medication disposal bin and two nurses are required for destruction. The process for controlled medication administration was to first remove the dose of controlled medication from the locked narcotic box in the medication cart. After removal, verify count, document the count in the narcotic book, administer, and after administration document on the residents MAR. He said the E-KIT is medication supply used if the facility is waiting for delivery of residents' medications from the pharmacy. He said if a resident needed a medication, such as pain medication, and the residents' medications had not arrived from pharmacy, they removed medications from the E-KIT.

During an interview, the AP said one evening she was at the medication cart lost her balance and knocked over resident's 1 pill bottle of Adderall. She said two nurses are required for controlled medication destruction to ensure medications are not diverted. RN-A counted the dropped Adderall tablets with her. They were unable to access the medication disposal bin for destruction. RN-A told her to keep the dropped Adderall tablets in the medication cart until the next day when they could access the medication disposal bin. The AP said she could not leave the dropped tablets in the medication cart due to the possibility of someone taking them, so she flushed the Adderall tablets down the toilet. She said RN-A did not witness her flush the medications. Later that evening, she noticed additional dropped Adderall tablets in the medication cart drawer and could not find RN-A. She said she made a bad decision and flushed those tablets down the toilet without a second nurse to count or witness destruction. During the same interview, The AP said medical provider orders are needed to administer controlled medications to residents. The AP said she removed a fourth dose of Adderall for resident 1 without orders because resident 1 said the AP did not give her a dose and Resident 1's MAR indicated she received all her scheduled doses. She said it was a "little scary", but she removed and administered a fourth dose without orders and did not contact a medical provider. The AP said the process for controlled medication administration was to remove the ordered controlled medication from the locked narcotic box in the medication cart, document removal in the narcotic book, administer, and document administration on the residents MAR. She said documentation on the MAR verifies the controlled medication administered to the resident. She said the E-KIT is emergency drug supply used when medications had not arrived from pharmacy. Residents need an active order from a medical provider for a nurse to have authorization to remove controlled medication from the E-KIT. When the medical provider ordered controlled medication, the date ordered is indicated on the MAR. She said if a resident had controlled medication supply in the medication cart there would be no reason to remove controlled medication from an E-KIT. The AP said she administered all the controlled medications removed from the E-KIT to resident 2. She said when she worked on her unit it got busy, so it was possible she did not document controlled medication administration on the MAR. The AP said she did not take resident 1's Adderall or resident 2's oxycodone, tramadol, or Lortab out of the building.

A review of the law enforcement report indicated the facility notified the police.

In conclusion, 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: Yes, except for resident 1, attempted but did not reach.
Family/Responsible Party interviewed: No, resident 1 and resident 2 responsible for self.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility placed the AP on suspension pending internal investigation. The AP is no longer employed by 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
Rice County Attorney
Faribault City Attorney

Faribault 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
	00568	A. BUILDING: _____ B. WING _____	C 01/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

POC NOT FINAL

(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 #H5090060M, 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 #H5090060M, 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: Based on interviews and document review, the facility failed to ensure two of two residents reviewed (R1, R2) were free from maltreatment. R1 and R2 were financially exploited. On September 30, 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		