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 #: H51141701M
Compliance #: H51148606C

Date Concluded: April 9, 2024

Name, Address, and County of Licensee Investigated:
Harmony River Living Center
1555 Sherwood Street Southeast
Hutchinson, Minnesota 55350
McLeod County

Facility Type: Nursing Home

Evaluator's Name: Nicole Myslicki, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Investigation:
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) financially exploited a resident when the AP replaced administration of oxycodone with aspirin.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP, a licensed practical nurse, documented on both the medication administration record (MAR) and narcotic log book, she administered oxycodone (an opioid pain medication) and gabapentin (a seizure medication used for nerve pain) to the resident. A facility nurse found the medication cup of the lunch time scheduled medications in the resident's medication cupboard. The cup contained one half tablet of 81 milligram (mg) aspirin (a medication used to help prevent heart attack or stroke) instead of 5 mg of oxycodone as ordered and was also missing 600 mg of gabapentin. The resident confirmed she did not receive her lunch time medications.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident report, personnel files, staff schedules, law enforcement reports, and related facility policy and procedures.

The National Association of Drug Diversion Investigators (NADDI) website included glossary information on the drug classification of Gabapentinoids, which includes gabapentin. NADDI indicated when ground up and snorted, the drug can produce a cocaine-like high. In addition, the drug can increase the effects of Suboxone (an opioid medication used to treat opioid addiction or used to treat pain) and Narcan (medication used to prevent overdose). The FDA (Food and Drug Administration) and Drug Enforcement Administration have advocated to designate gabapentin as a controlled substance to counter misuse.

An article published in the Dove Press (a scientific medical research journal) titled, "Gabapentin use, abuse, and the US opioid epidemic: the case for reclassification as a controlled substance and the need for pharmacovigilance," indicated gabapentin abuse occurs because it increases the effects of opioids when taken.

The resident resided in a Transitional Care Unit (TCU) within a nursing home. The resident's diagnoses included a fracture. The resident's care plan included assistance with medication administration. The resident's assessment indicated the resident frequently had pain which made it hard for her to sleep at night or complete day-to day activities. The assessment identified the resident as oriented to person, place, and time.

The resident's medication orders included oxycodone 5 mg by mouth every four hours as needed (PRN) for severe pain, acetaminophen 1000 mg by mouth three times daily for pain, and gabapentin (a medication used to treat nerve pain) 600 mg by mouth three times daily for pain. The resident's record did not include an order for one half of an 81 mg tablet of aspirin daily.

The resident's MAR indicated the AP documented she administered gabapentin 600 mg, acetaminophen 1000 mg, and oxycodone 5 mg at 12:30 p.m. The AP indicated the resident had a pain level of eight out of 10 at the 12:30 p.m. medication pass. The AP also documented the oxycodone had been effective in relieving pain.

The facility narcotic book log indicated the AP documented she removed one half tablet of oxycodone at 12:30 p.m. the day of the incident.

A facility incident report indicated nurse 1 began to administer the resident's evening medications. Upon opening the resident's medication cupboard, nurse 1 found a medication cup on the shelf which contained two white, oblong, whole pills, and one half of a round, peach tablet (no gabapentin). Nurse 1 told the resident what she found in the medication cupboard.

The resident told nurse 1 it must have been from when the AP came into her room to give medications during lunch time, but stated she would lock them up in the cupboard and come back to give them later, since the resident had been in the bathroom at the time. Nurse 1 took the medication cup to the medication cart to determine which medications they were and what time they should have been given. Nurse 1 checked the electronic medication administration record (EMAR) and noticed the AP documented she administered acetaminophen and oxycodone at 12:30 p.m. Nurse 1 recognized the peach-colored half tablet did not resemble the resident's current supply of oxycodone which were bright pink in color. Nurse 1 identified the half tablet in the medication cup as aspirin 81 mg non-enteric coated, consistent with the facility stock supply kept in the medication cart.

The facility internal investigation indicated the resident reported the AP must have forgotten to come back to administer the lunch time medications. After discovering the medication omission, nurse 1 questioned the resident about her pain level, and the resident denied pain or the need for PRN medication at that time. This investigation included interviews with various staff members. Staff members reported the AP destroyed narcotics without a witness. Staff members also reported many times, residents asked why their pain medications changed colors from day to day. One nurse reported a resident stated the AP had been giving her a red pill all weekend. The nurse had to show the resident the medication card to prove the pain medication had been an orange tablet, not red. Another nurse reported she had to coach the AP on not giving PRN narcotic pain medication so often.

The facility took photographs of the medication cup with medications inside and photographs of the resident's medications for identifying. The oxycodone compared to the half tablet of aspirin showed the oxycodone had been a brighter pink color, while the half tablet of aspirin had been a light peach color. The prescription on the oxycodone described the pill as pink and round, with identifier K 56. The aspirin identifier had been AZ 013. The half tablet of aspirin had a Z and 3 identifiable on it.

A law enforcement report indicated they spoke with staff and reviewed the facility's internal investigation of the incident. Based on information provided, law enforcement believed the AP had been removing narcotics from the facility illegally. Evidence corroborated suspicions the AP had not been following facility protocols related to medication administration and disposal. The report also indicated it appeared the AP purposefully deprived the resident of oxycodone by replacing it with aspirin, intending to administer it as if it were oxycodone.

A second law enforcement report indicated they executed a search warrant of the AP's home. Among other items, law enforcement discovered a pill cutter.

The AP's personnel record indicated she passed skill checkoffs on charting in the narcotic book, medication pass procedure, PRN medication expectations, standing orders, and medication destruction and documentation.

During an interview, nurse 1 stated residents had a lockable medication cupboard in their rooms for prescribed medications. The unit also had a lockable medication cart which contained facility supplied over the counter medications, as well as a lockable box within the cart, which contained residents' controlled substances. Nurse 1 stated she started the resident's evening medication pass when she found the medication cup in the resident's medication cabinet. Nurse 1 initially thought the AP forgot to give the resident her blood pressure medication, since the resident's blood pressure had been elevated. After observing the medications in the cup and comparing them to the medications signed out in the MAR, as well as the remaining supply, nurse 1 realized the half tablet in the medication cup could not have been oxycodone. Nurse 1 compared the half tablet in the medication cup to the facility supply of 81 mg aspirin, and they looked exactly the same. Nurse 1 asked the resident what the medications were. The resident told her she was supposed to get her acetaminophen and pain pill earlier that day, but she had been in the bathroom when the AP came in to administer the medications. The AP told the resident once she finished up in the bathroom, she would come back and give her the medications. Nurse 1 stated she checked the narcotic log book and saw the AP documented administering 5 mg of oxycodone during that medication pass. The MAR indicated acetaminophen, gabapentin, and PRN oxycodone were given.

During an interview, nurse 2 stated the resident had been in the TCU for a physical need and was mentally appropriate, coming from a home setting where she had overseen her own medications. The TCU had one nurse and two unlicensed personnel (ULP) on the day shift. Only the nurse on duty had the key to the narcotic box within the locked medication cart, as well as the key to the locked medication cupboards located in resident rooms. Nurses kept these keys on their person during the shift. The evening of the incident, nurse 1 called and informed her of the medication issue. Nurse 2 instructed nurse 1 to take pictures of the medications and send them to her for verification. Nurse 2 also instructed nurse 1 to complete a pain assessment on the resident and have a facility-wide count of all controlled substances completed immediately. The facility placed the AP on administrative leave and completed an internal investigation. This included pain assessments for all residents on pain medication, and every resident the AP had worked with the prior two weeks. Nurse 2 spoke with the resident who gave her the same information she gave nurse 1. The resident felt her pain had been okay. The facility also interviewed other staff and audited all controlled substances and narcotic log books. After the incident, the facility completed one-to-one education with staff regarding policies and procedures related to controlled substances. Then, a month later, they completed a more formal education with staff on drug diversion.

During an interview, the resident's family member stated the resident would have been cognitively fine at the time of the incident. The family member stated the resident thought her pain reliever had not been working as well as it should have during that time.

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:
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

Vulnerable Adult interviewed: No. Unable to interview due to health status.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No. The AP declined to interview.

Action taken by facility:
The facility contacted law enforcement, completed an investigation, and educated all staff administering medication. The AP was no longer employed at the facility.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, and substantiated facility noncompliance. 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

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies. 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
McLeod County Attorney
Hutchinson City Attorney
Hutchinson 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
	00348	A. BUILDING: _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY RIVER LIVING CENTER	1555 SHERWOOD STREET SOUTHEAST HUTCHINSON, MN 55350

(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 #H51141701M, 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 #H51141701M, 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 one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the individual 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 is required for this tag.	