Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52336607M
Compliance #: H52331679C

Date Concluded: February 12, 2024

Name, Address, and County of Licensee Investigated:
Saint Anne Extended Healthcare
1347 West Broadway Street
Winona, MN 55987
Winona County

Facility Type: Nursing Home

Evaluator's Name: Holly German, 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 took the resident's narcotic pain medication patch for her own personal use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP stated she took the resident's pain medication patch and placed it on her own body for her own use.

The investigator conducted interviews with facility staff administrative staff and the AP. The investigation included review of the resident's records, facility internal investigation, personnel files, staff schedules, law enforcement report, and related facility policies and procedures.

The resident resided in a skilled nursing facility. The resident's diagnoses included bipolar disorder, schizoaffective disorder, chronic pain syndrome, and osteoarthritis. The resident's

care plan included assistance with transfers and medication administration. The resident's assessment indicated the resident had cognitive impairment with short term memory impairment and used a walker.

The resident received a controlled substance medication patch for pain per medical provider order. Facility staff noted the patches appeared tampered with and initiated further monitoring techniques including placing specific markings on the patches and taking pictures for comparison. When a patch appeared tampered with due to changes in the markings, the facility notified law enforcement.

A facility investigation report indicated a law enforcement officer interviewed the AP, at which time the AP reported she had taken the medication patch. The law enforcement report indicated the AP removed the patch from her body and gave it to the law enforcement officer. At that time, the AP stated she took the patch off the medication cart when a nurse was in the process of wasting it with another nurse.

During an interview, the administrator stated staff noted a concern with the medication patch appearing wrinkled. The facility initiated additional monitoring and two weeks later another concern came forward when a nurse stated she did not think the handwriting on the patch was hers as it should have been. The administrator stated the photos taken helped identify the different handwriting on the medication patch. The administrator stated they notified law enforcement who interviewed staff in their investigation, including the AP, who said she took the patch for her own personal use.

During an interview, a nurse stated another nurse came to her with concern that it was not her initials on the medication patch when it should have been since she was the one to place it last. The nurse stated the following day there was an obvious noted tamper to the resident's patch. The nurse stated she notified law enforcement. The nurse stated the AP reported to law enforcement she had taken the patch, and continually apologized to her. The nurse stated the AP told her she took the patch from the resident.

During an interview, the AP acknowledged receiving training about abuse and neglect throughout her employment. The AP stated she saw a medication patch on the resident's bedside table. The AP stated she took the patch the resident was wearing off the resident and placed it on herself. The AP then placed the patch she obtained from the bedside table and placed in on the resident. The AP stated she took the patch to get herself out of pain. The AP could not recall if she wrote another staff members initials on the patch she placed on the resident.

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;
(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 Adult interviewed: No, unable to be interviewed due to cognitive impairment.
Family/Responsible Party interviewed: No, unable to contact.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility implemented tamper monitoring methods when suspected diversion. The facility contacted law enforcement and the AP is no longer employed by 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
Winona County Attorney

Winona City Attorney
Winona Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00955	A. BUILDING: _____ B. WING _____	C 12/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY STREET WINONA, MN 55987

(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 #H52336607M and #H52339306M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.	2 000	No plan of correction is required for this tag.	

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2 000	Continued From page 1 The following correction order is issued for #H52336607M, 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(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, an individual person 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.	