Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52359726M
Compliance #: H52357224C

Date Concluded: April 12, 2024

Name, Address, and County of Licensee Investigated:

Woodbury Health Care Center
7012 Lake Rd
Woodbury, MN 55125
Washington County

Facility Type: Nursing Home

Evaluator's Name:
Jana Wegener, 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 resident was financially exploited by drug diversion when the alleged perpetrator (AP), took the resident's Oxycodone (narcotic medication) for her own purpose.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation and neglect occurred. The AP was responsible for the maltreatment. Financial exploitation by drug diversion occurred when the AP removed 3 of the resident's discontinued Oxycodone but did not administer them. Based on a preponderance of evidence, the AP took the residents Oxycodone for her own personal use. In addition, the AP neglected multiple residents when observed on recorded video repeatedly dispensing multiple residents prescribed medications, throwing the medications into a trash bin, and not administering the residents their prescribed medications.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family and law

enforcement. The investigation included review of the resident record(s), facility internal investigation, facility video surveillance footage, facility incident reports, police reports, staffing agency personnel files, staff schedules, previous federal investigation documentation, and related facility policy and procedures.

The resident resided in a nursing home with diagnoses including spinal stenosis of cervical region, hemiplegia (paralysis on one side of the body) following a stroke, seizures, and dementia without behavioral disturbance.

The resident's assessment and care plan at the time of the incident indicated the resident was cognitively impaired, had no pain, and received medication management services. The resident's pain assessment indicated the resident did not utilize narcotic pain medications.

The resident's medication administration record (MAR) did not include orders for the resident to receive Oxycodone medication at the time the incident occurred.

The resident record indicated on admission the resident was prescribed Oxycodone 5 milligrams (mg) every four hours as needed for pain. The resident record indicated the resident utilized the medication a few times for the first couple of weeks then the order was discontinued.

The facility investigation indicated a nurse reported concerns with forgery and potential diversion of the resident's discontinued Oxycodone. The investigation indicated the resident was transferred from the first floor to the second floor. The resident's medications including the discontinued Oxycodone were transferred to the second-floor narcotic logbook and secured in the medication cart lock box. The investigation indicated while completing a change of shift narcotic count the following day, the nurse who had admitted the resident and entered the Oxycodone medication into the narcotic logbook, noted the logbook had 3 administered doses of the resident's discontinued Oxycodone. The nurse identified 2 of 3 administration times were on the shift she worked the previous day, and one of the times entered was prior to when the resident and medication were transferred and entered into the narcotic logbook. The investigation indicated all staff with access to the resident's Oxycodone were observed on the facilities recorded video footage for possible diversion with no concerns of diversion other than the AP. The facility investigation indicated the video showed the reporting nurse had not accessed the narcotic lock box during the times documented in the narcotic logbook. The facility investigation indicated when video was reviewed the AP was observed dispensing narcotic medications, including the resident's 3 Oxycodone tablets, putting them into her pocket, and never entered the resident rooms to administer the narcotics. The facility investigation identified 10 other residents were prescribed controlled narcotic medications that the AP potentially diverted. The AP was also observed dispensing numerous resident's prescribed, scheduled medications. The AP prepared the medications and then threw them into the trash, and never entered the resident's rooms to administer the medications. The facility investigation identified up to 21 residents were neglected when the AP failed to administer medications as prescribed. The facility investigation included a log of the following video surveillance:

- At 2:45 p.m. the AP was observed completing a change of shift narcotic count with the off going nursing staff.
- At 3:17 p.m. the AP took the resident's discontinued Oxycodone out of the lock box in the medication cart, documented in the narcotic logbook, put the resident's Oxycodone into a medication cup, placed the cup into the top drawer of the medication cart, and moved the cart down the hall. The AP did not enter the resident's room.
- At 3:24 p.m. the AP went into the top drawer where she had placed the resident's Oxycodone and put it in her pocket. The AP did not enter the resident's room.
- At 7:21 p.m. the AP placed a [unknown] narcotic into a med cup, then took out the resident's discontinued Oxycodone, and documented in the narcotic logbook. The AP punched out another dose of the resident's Oxycodone into a med cup and put it in the top drawer of the medication cart.
- At 8:14 p.m. the AP accessed the narcotic lock box, grabbed out a narcotic card, documented in the logbook, and then punched the narcotic medications into a medication cup. The AP then accessed other drawers in the medication cart for regular scheduled medications and was observed punching the medications out of the bubble packs into her hand and throwing the medications directly into the trash can on the medication cart. The AP opened the top drawer, retrieved the medication cup with the resident's Oxycodone, and punched out other regular scheduled medications into new cups.
- At 8:18 p.m. the AP threw the medications she just prepared into the cart's trash. Then, the AP was observed going through multiple medication cards, removing the medications and putting them into medication cups, and throwing the medications in the trash.
- At 8:21 p.m. the AP reopened the narcotic lockbox, removed a narcotic, and documented in the narcotic logbook. The AP was in the residents' room a short time. When the AP exited the resident's room she put her hand in her left scrub pocket, shuffled the contents of the medication cup into her right hand, and threw the cup away.
- At 8:23 p.m. The AP reopened the top drawer, poured the contents of several cups together and threw away the empty cup. The AP placed the cup with narcotics in it on top of the cart, then put the cup into her left scrub pocket.
- At 9:41 p.m. the AP removed the trash bag out of the medication cart.
- At 9:53 p.m. The AP opened the narcotic lock box, grabbed the narcotic logbook, removed a medication cup from the lock box, and placed it on the side of the medication cart. The AP poured a glass of water and appeared to ingest the narcotics.
- At 10:38 p.m. the AP completed a change of shift narcotic count with the oncoming nursing staff. A conversation between the AP and the oncoming nurse indicated the narcotic count was off, with one medication card having an extra narcotic that was signed out in the logbook but not given. The investigation indicated the AP reported to the nurse coming on shift she forgot to give the narcotic. The AP was observed removing

the narcotic and putting it into a medication cup, putting it into her pocket, and returning to the nurse's station without administering the narcotic to the resident.

A police report indicated an officer observed 3 narcotic logbook entries, all the entries had different names, but appeared to be similar handwriting. The police report noted the AP was observed on facility video surveillance accessing the narcotic box, and dispensing medications that were never administered to residents. The police report indicated the AP was observed reaching into her pockets or putting something into her mouth as if she was taking the medication herself.

A previous federal investigation indicated two investigators observed the facility video surveillance footage and confirmed the findings from the facility. When interviewed by the investigators the AP denied all allegations of diversion and neglecting to give resident's their narcotic or prescribed medications.

When interviewed the nurse who reported the concern with diversion and forgery stated the signature in the narcotic logbooks first documented administration of the residents Oxycodone appeared to start with a "V", and indicated it appeared the AP attempted to forge her signature. The nurse stated the signature was not hers, and explained it lacked specific traits in her signature. The nurse stated the other signature was also falsely documented as being administered on her shift and had an unrecognizable signature. The nurse stated the last log entry was for the AP, indicating she administered a dose of the medication at 6:00 p.m. The nurse stated when she gave report to the AP the previous day, she did not report the time the resident came to the second floor. The nurse explained the narcotic logbook page did not even exist at the times the AP falsely documented the administrations occurred. The nurse stated the resident had no orders for the Oxycodone to be administered and immediately reported the concerns.

When interviewed another nurse who transferred the medication from first floor to second floor verified the nurse who received the resident's discontinued Oxycodone medication entered the correct quantity into the second-floor logbook on a new blank page. The nurse stated there were no administration entries on the page because the resident had no orders for the medication.

When interviewed a nursing manager stated the narcotic logbook appeared to have the same handwriting for each of the 3 administration times documented, including the one signed off as given by the AP at 6:00 p.m. The nurse manager stated the AP falsely documented administration times at 10:00 a.m. and 1:00 p.m. prior to her shift and appeared to have forged other nurse's signatures. The nurse manager stated the resident had no orders for Oxycodone, and the time documented was prior to when the resident and his medications were transferred to the new unit and entered into the second-floor narcotic logbook. The nurse manager stated the AP was observed on video throwing away multiple other resident's medications. The nurse

manager stated approximately 21 residents had not received their medications as ordered because the AP dispensed them and threw them away.

When interviewed the AP denied the allegations of diversion and neglect and denied falsely documenting administration of the resident's Oxycodone. The AP stated she "did not take any resident medications not for herself, not for my own use". The AP stated she recalled throwing one resident's medication in the trash because the resident was out of the facility, and another resident had refused bedtime Tylenol. The AP indicated if a resident refused a medication or was out of the facility and she was unable to administer it she would document it in the resident record. The AP denied putting the resident's narcotic medications into her pocket. The AP stated she had her own Tylenol in her pocket that she took between 5:00 p.m. and 7:00 p.m. with water from the medication cart, and again denied taking resident narcotics. The AP correctly explained proper procedure for administering medications including controlled drugs, and as needed controlled drug administration. The AP could not explain why she documented administering discontinued Oxycodone to the resident, or the conduct observed on the facility video surveillance. The AP stated she made mistakes that night, however, she states she did not take the residents medication(s).

When interviewed leadership staff stated the video that was reviewed showed the AP removed the resident's Oxycodone card and document in the narcotic logbook, she administered the medication to the resident even though he had no orders for the medication. Leadership staff stated the AP was not observed enter the resident's room to administer medications and had odd conduct like putting the controlled drugs in drawers, dumping them together, and putting them in her scrub pockets. The AP was observed punching out multiple residents prescribed medications directly into her hand, or a medication cup, and then immediately threw them in the trash with no attempt to administer them. Leadership staff indicated a medication error report was completed for 21 residents who were potentially affected by the AP not administering medications as prescribed, and indicated the AP was rarely seen enter a resident's room to administer medications during her shift. Leadership staff stated all the residents were monitored for several days after the incident with no adverse effects noted.

In conclusion, the Minnesota Department of Health determined financial exploitation and neglect 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;
(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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, unable
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility reported the concerns to the Minnesota Adult Abuse Reporting Center (MAARC), and the AP's staffing agency. The facility investigated the concern, identified other residents who were potentially neglected by the AP, reported to the resident's providers, and monitored the residents for adverse effects.

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.

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
Washington County Attorney
Woodbury City Attorney
Woodbury Police Department
Drug Enforcement Administration

Department of Human Services
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00803	A. BUILDING: _____ B. WING _____	C 03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	7012 LAKE ROAD WOODBURY, MN 55125

(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 #H52359726M/# H52357224C, 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	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 #H52359726M/# H52357224C, 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	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is 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 evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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	21850		

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21850	Continued From page 2 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. 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 individual person(s) were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	21850		