Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52392063M
Compliance #: H523933550C

Date Concluded: March 15, 2023

Name, Address, and County of Licensee Investigated:
Guardian Angels Health and Rehab Center
1500 Third Avenue East
Hibbing, MN, 55746
Saint Louis County

Facility Type: Nursing Home

Evaluator's Name: Angela Vatalaro, 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), a nurse, financially exploited resident 1 and resident 2 when the AP failed to administer resident 1 and resident 2's narcotics.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. There was a pattern of behavior to support preponderance of evidence the AP removed resident 1 and resident 2's narcotics. Medication administration records lacked documentation the residents received narcotic medications, although the narcotic record indicated the AP removed those medications. In addition, the AP had the same pattern of diversion with additional residents' narcotics.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The AP did not respond to a subpoena for an interview. The investigator contacted law enforcement and reviewed the law enforcement report. The investigation

included review of resident 1 and resident 2's medical records, other residents' medical records, narcotic records, Minnesota Department of Health (MDH) survey notes, facility internal investigation notes, the AP's personnel file, and facility policies related to controlled substances and drug diversion.

The facility's internal investigation indicated one day licensed practical nurse (LPN 1) reported suspicious documentation on narcotic records that indicated the AP removed narcotics for resident 1 and resident 2 during the previous overnight shift. The internal investigation indicated resident 1 and resident 2, cognitively intact residents, both stated they did not receive the narcotics removed by the AP. The AP's timecard indicated the AP worked the overnight shift. The AP punched in at 10:23 p.m., and punched out at 7:15 a.m.

Resident 1 resided in a nursing home. Resident 1's diagnoses included a hip fracture. Resident 1's care plan included potential for pain related to a recent surgery, and staff administer medication as ordered. The same care plan indicated resident 1 was able to express her needs. Resident 1's Brief Interview of Mental Status (BIMS) test indicated resident 1 was cognitively intact.

Resident 1's narcotic records included orders for oxycodone (opioid pain medication). The facility's internal investigation indicated LPN 1 started to do her medication pass when she noted two separate occasions resident 1 received oxycodone during the previous shift. Resident 1 told LPN 1 she took nothing throughout the night and denied pain. The facility internal investigation indicated 37 doses of resident 1's oxycodone was removed in a 24-day time frame. The AP removed 14 of the 37 doses either in the middle of the night or early morning around 5:00 a.m. Resident 1's medication administration record (MAR) indicated the AP administered two of 14 doses. The same MAR did not indicate the AP administered the other 12 doses removed. The facility internal investigation indicated resident 1 stated she never asked for her pain medication during the overnight shift. Overnight staff members interviewed stated resident 1 did not request pain medications during overnight shift.

MDH surveyor notes indicated the surveyor spoke to resident 1. Resident 1 stated she did not receive oxycodone during the overnight shift. Resident 1 stated overnight staff never asked her if she needed oxycodone and she had not taken oxycodone during the overnight.

Resident 2 resided in a nursing home. Resident 2's diagnoses included spinal stenosis (compression of the spinal cord). Resident 2's care plan included chronic pain related to back surgery, and staff administer medication as ordered. The same care plan indicated resident 2 was able to express his needs. Resident 2's BIMS test indicated resident 2 was cognitively intact.

Resident 2's narcotic records included orders for Percocet (opioid pain medication). The facility's internal investigation indicated LPN 1 went into resident 2's room and she noted on two separate occasions resident 2 had Percocet removed during the previous overnight shift. Resident 2 told LPN 1 he did not take or ask for pain pills during the overnight shift. The facility

internal investigation indicated 25 doses of resident 2's Percocet was removed in a 10-day time frame. The AP removed nine of the 25 doses. The AP removed three of the nine doses at 1:00 a.m. Resident 2's MAR did not indicate the AP administered two of three doses removed at 1:00 a.m. The facility internal investigation indicated resident 2 stated he never received pain medication in the middle of the night. Overnight staff members interviewed, and they stated resident 2 did not request pain medications during the overnight.

MDH surveyor notes indicated the surveyor spoke to resident 2. Resident 2 stated he did not receive Percocet at 1:00 a.m., during the overnight shift.

The facility's internal investigation indicated 21 residents had a narcotic audit performed. Six of the 21 residents had medication diversion concerns.

The facility internal investigation indicated a third resident's narcotic record included orders for oxycodone. The AP removed 13 of 14 doses. The internal investigation indicated this was an unusual pattern when only one nurse gave pain medications. The MAR did not indicate the AP administered four of the 13 doses removed. A fourth residents narcotic record included orders for hydrocodone (opioid pain medication). The AP removed three doses and the MAR did not indicate the AP administered two doses removed. The internal investigation indicated the AP removed a dose at 1:00 a.m. During facility staff interviews, staff reported the resident slept throughout the night and did not ask for pain medication. A fifth resident's narcotic record included orders for hydrocodone. The resident's hydrocodone was removed 13 times, of those 13 times the AP removed eight doses. The MAR did not indicate the AP administered the eight doses removed. A sixth resident's narcotic record included orders for Tramadol (opioid pain medication). The facility's internal investigation indicated Tramadol was removed 20 times. Of those 20 times, the AP removed 11 doses. The AP removed one dose within six hours, not following the ordered directions.

The law enforcement report indicated the facility reported the incident.

The AP's personnel record indicated the AP received vulnerable adult, medication administration, and pain management training.

During an interview, LPN 1 stated during morning medication pass she noticed resident 1 had pain medications removed twice during the overnight shift. She asked resident 1 if her pain medications were effective. Resident 1 stated she did not take any pain medications during the overnight. That same day, LPN 1 noticed resident 2 had pain medications removed during the overnight shift. LPN 1 asked resident 2 if his pain medications were effective. Resident 2 stated he didn't take any pain medications during the overnight. LPN 1 stated both resident 1 and resident 2 were alert, oriented, and would ask for pain medications when they needed them. LPN 1 stated when staff removed narcotics staff documented administration of narcotics on the electronic MAR.

During an interview, a social services staff member stated both resident 1 and resident 2 were cognitively intact and both residents told her they did not receive pain medication during the overnight shift.

During an interview, a registered nurse stated staff were trained and it was an expectation to document administration of narcotics on the electronic MAR. This documentation indicated the residents received the narcotics removed. For the internal investigation, she stated she conducted a narcotic audit. The AP had a pattern of removing residents' narcotics and not documenting narcotics administered. The AP had a pattern of removing narcotics at certain times when the residents did not receive narcotics at those times from other staff. She stated there was a pattern of residents stating they did not receive the narcotics removed during the AP's overnight shift.

During an interview, leadership staff stated he spoke to the AP. The AP denied the allegation of drug diversion and the AP stated the residents received the narcotic medications removed.

During an interview, resident 1 stated she did not request or receive her oxycodone during the overnight shift.

During an interview, resident 2 stated he did not receive his Percocet in the middle of the night.

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: Yes.
Family/Responsible Party interviewed: Yes, except resident 2 was responsible for self.
Alleged Perpetrator interviewed: No. Did not respond to subpoena.

Action taken by facility:
The facility conducted an internal investigation, contacted law enforcement, and provided re-education to licensed staff on accurate documentation of pain medication. 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
Saint Louis County Attorney
Hibbing City Attorney
Hibbing 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
	00858	A. BUILDING: _____ B. WING _____	C 02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTI	1500 EAST THIRD AVENUE HIBBING, MN 55746

(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 #H52392063M, 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 #H52392063M, 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	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." Following the evaluators findings are the Suggested Method of Correction and the 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	21850		

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21850	Continued From page 2 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. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual staff 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 (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	