Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54203546M **Date Concluded:** August 27, 2024

Name, Address, and County of Licensee Investigated:
Lakewood Health System
401 Prairie Avenue NE
Staples, MN 56479
Wadena County

Facility Type: Nursing Home **Evaluator's Name:** Deb Schillinger, RN
Special Investigator

Finding: Inconclusive

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 residents when the AP took the residents medication for personal use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was inconclusive. The facility's security video showed the AP, who was a licensed practical nurse, at a medication cart and, while she did at times eat food while passing medications, it was inconclusive she diverted resident's medications.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator contacted law enforcement. The investigation included review of resident records, facility internal investigation, security video footage, personnel files, staff schedules, and related facility policy and procedures.

One day, upon viewing video security cameras, the facility identified a concern regarding the AP and possibility of the AP using resident's medications for her own use. The facility initiated an investigation because it appeared the AP placed pills in her mouth while doing the medication pass.

The investigation included a review of the facility's security footage regarding the AP's possible diversion of resident medications. The footage showed the AP eating at the medication cart but gave no clear examples of the AP taking resident medications and placing those medications in her mouth. There was one occasion the video showed the AP place what appeared to be a pill in her mouth, but the view was obstructed, and it was not clear it was a resident's medication.

During an interview, nurse #1 stated the AP had no reports or suspicions of diversion of medications prior to viewing security video.

During an interview, nurse #2 stated she had not been alerted of any concerns from residents or other facility staff regarding the AP, no resident reports or documentation reflecting unmanaged pain from residents, abnormal wasting of medications or reports of missing narcotics when the AP was working.

During an interview, the AP denied taking medication from the resident's supply for her own personal use. The AP stated at times she ate while passing medications at the cart. The AP also reported she took Tylenol throughout her shift that she had used from stock medications within the medication cart at times.

In conclusion, the Minnesota Department of Health determined financial exploitation was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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.

Vulnerable Adult interviewed: Not Applicable

Family/Responsible Party interviewed: Not Applicable
Alleged Perpetrator interviewed: Yes

Action taken by facility:
While the AP was no longer employed at the facility at the time, the facility conducted an investigation. The facility also provided additional training to current employees to prevent the risk of drug diversion.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00667	A. BUILDING: _____ B. WING _____	C 08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD HEALTH SYSTEM	401 PRAIRIE AVENUE NORTHEAST STAPLES, MN 56479

(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 #H54203546M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		