Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54227168M
Compliance #: H54222946C

Date Concluded: February 9, 2024

Name, Address, and County of Licensee Investigated:
Milaca Elim Meadows Health Care
730 2nd St SE,
Milaca, MN 56353
Mille Lacs County

Facility Type: Nursing Home

Evaluator's Name: Brandon Martfeld, RN BSN
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.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) financially exploited the resident when the AP took a resident's narcotic medication for personal use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP, a nurse, was responsible for the maltreatment. The AP admitted to taking the resident's Oxycodone (opioid) medication and recorded video surveillance showed the AP removing a medication punch card from the narcotic lock box.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and completed an interview with the AP. The investigation included review of medical records, facility schedules, police report, video footage, facility incident report, facility policies, and the AP's personnel file.

The resident resided in a nursing home. The resident's diagnoses included amputation of the left foot, pain, and depression. The resident's care plan indicated the resident was alert and oriented and had pain due to amputation of the left toes. The resident's minimum data set (MDS) indicated the resident needed assistance with dressing, transfers, toileting, and required scheduled and as needed pain medication.

The facility's incident report indicated at the end of one shift, two nurses completed the narcotic count (reconciliation) at the medication cart. During the narcotic count, one nurse reviewed the narcotic record book, while the other nurse went through the narcotic lock box containing the narcotic medication punch cards that was stored on the medication cart. The narcotic record book contained a page for the resident of Oxycodone 5 milligrams with a total of 24 tablets left on the card. The nurses were not able to locate the medication punch card containing the medication.

The police report indicated one day a medication punch card of Oxycodone 5 milligrams (mg) was missing from the medication cart. The police report indicated recorded video footage of the medication cart revealed the AP taking the medication punch card. The AP went to the police station and admitted to taking the medication punch card containing Oxycodone. The AP stated she took the entire card of the resident's medication because the AP was having pain. The AP said she took several doses of the medication, including taking two pills the day before speaking with the police. The AP then stated she destroyed the remaining Oxycodone pills.

Review of the recorded video footage showed the AP removing a medication punch card from the narcotic box of the medication cart. While holding a clipboard in her left hand, the AP placed the medication punch card behind the clipboard and between her fingers. The AP closed the narcotic lock box lid, placed the clipboard with the medication card underneath the clipboard on top of the medication cart, and closed the drawer on the medication cart. The recorded video footage showed the AP at the medication cart while two staff members come into to the nurse's station and gather supplies. Once the two staff members leave the nurse's station area and are out of view, the AP took the clipboard over to a bag behind the nurse's desk. The AP squatted down by the bag, placed items into the bag, stood up with the clipboard in her hand and the bag on her right shoulder. The AP walked down the hallway out of view of the camera.

During an interview, a nurse stated during shift change the oncoming nurse counted the narcotics with the nurse leaving her shift. During the count, the nurse opened to a page in the narcotic record book that indicated the resident had a narcotic punch card containing oxycodone 24 tablets. The other nurse counting the narcotic box indicated there was no medication punch card for the resident's narcotic. The nurse reviewed the narcotic book and there was no documentation of the narcotic being destroyed or removed from the narcotic box. The nurse stated the resident had not required any of the narcotic medication from the card. The nurse and another nurse searched the facility's other medication carts, searched an extra narcotic lock box, and alerted the on-call nurse of the missing narcotic punch card.

During an interview, a social worker stated she reviewed the recorded video footage and observed the AP taking a narcotic punch card from the lock box from the medication cart. The social worker stated it was odd that the AP was in the lock box three or four times during the overnight because other nurses that were reviewed on recorded video during an overnight shift did not go into the narcotic lock box. Leadership was notified of the video footage evidence.

During an interview, leadership stated once the recorded video footage was reviewed, the police were notified and the staffing agency that the AP was hired through, was told not to have the AP return to the facility.

During an interview, the resident stated her pain was controlled when at the facility.

During an interview, the AP stated she took the narcotic medication from the medication cart. The AP stated she placed the narcotic medication punch card into her personal bag and brought the medication home. Once at home, the AP took four pills from the medication card, and flushed the rest of the medication down the toilet.

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" 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: No. Resident was responsible for self.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility notified the police department and completed an audit of the narcotic medications throughout the facility to ensure accurate account.

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
Mille Lacs County Attorney
Milaca City Attorney
Milaca 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
	00376	A. BUILDING: _____ B. WING _____	C 01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILACA ELIM MEADOWS HEALTH CARE CEN	730 SECOND STREET SOUTHEAST MILACA, MN 56353

(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 #H54227168M/#H54222946C, 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 #H54227168M/#H54222946C, 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 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.	