Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54267386M
Compliance #: H54263590C

Date Concluded: June 21, 2024

Name, Address, and County of Licensee Investigated:
Koda Living Community
2255 30th Street Northwest
Owatonna, MN 55060
Steele County

Facility Type: Nursing Home

Evaluator's Name: Rhylee Gilb, 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 residents when she stole residents' narcotic medications.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP documented in the residents' (resident 1, resident 2, resident 3, resident 4, resident 5) electronic medication administration records and the narcotic records, she withdrew and administered as needed narcotic medications. Resident interviews indicated they did not request nor receive narcotic medication from the AP. In addition, there was a preponderance of evidence the AP stole $300 and the wallet of resident 3.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and agency staff. The investigation included review of resident records, facility internal investigation, facility narcotic log records, the AP personnel file, staff schedules, law

enforcement report, related facility policy and procedures. Also, the investigator reviewed surveyor records from the onsite complaint visit and law enforcement report.

Resident 1 resided in a skilled nursing facility in the short-term rehabilitation unit. Resident 1's admission diagnosis was fracture of his left arm. Resident 1's Brief Interview for Mental Status (BIMS) score was 15 out 15, indicating intact cognition. Resident 1's progress notes and medication administration record (MAR) indicated his orders included scheduled Tylenol (over the counter pain medication) 500 milligrams (mg) three times per day and as needed oxycodone (narcotic pain medication) 5 mg every three hours for pain control while he awaited surgery. Six days after admission, resident 1's pain assessment indicated his arm as rest was 2 out 10 pain rating and at worst pain is 5 out of 10. Resident 1 did not want any changes to his medications. Resident 1's progress note the same day of the assessment indicated he felt surgery was going to be the best solution for resolving his pain.

Resident 1's MAR indicated the first week of admission he utilized oxycodone three to four times per day, then decreased use to twice on day 12, once on day 13, no use on day 14. The AP documented she administered three oxycodone to resident 1 during one evening shift on day 15. The MAR indicated the next day, resident 1 had no oxycodone use; a day the AP did not work. Days 17 and 18, nurse 1 documented she administered oxycodone once each day. The next day, resident 1 had no oxycodone use. Over the next 19 days leading to resident 1's surgery day, the AP documented she administered 14 oxycodone; over the 11 days she worked in that time frame. No other nurse administered oxycodone and there was no administration on days the AP did not work.

The narcotic log indicated there were four doses of oxycodone removed, but the MAR did not indicate an administration to resident 1. Three of the four doses were removed by the AP, the other dose was removed by nurse 1.

Resident 1's progress notes indicated he was out of the facility for two days when he received surgery. Upon re-admission, resident 1's MAR indicated the oxycodone order was discontinued and he had an order for as needed hydromorphone (narcotic pain medication). The scheduled Tylenol order increased to 1000 mg four times per day. The evening he readmitted, nurse 1 administered one hydromorphone and then resident 1 started receiving the Tylenol 1000 mg. Day two and three post-surgery, resident 1 did not use any hydromorphone. Over the next 11 days the AP documented she administered 12 hydromorphone; over the eight days she worked in that time frame. No other nurse administered hydromorphone and there was no administration on days the AP did not work.

The facility internal investigation included resident 1's interview. Resident 1 stated at the start of his stay initially his pain was not managed, but it was at the time of the interview. Resident 1 stated he had not been having pain nor taken any hydromorphone.

Resident 2 resided in a skilled nursing facility in the short-term rehabilitation unit. Resident 2's admission diagnosis was post total knee replacement. Resident 2's BIMS score was 15 out 15, indicating intact cognition. Resident 2's MAR included an order for Tylenol 1000 mg every six hours as needed and as needed oxycodone 5 mg to 10 mg (one or two tablets) every four hours. On day two resident 2 received one dose of Tylenol and on day three the Tylenol order changed to 1000 mg scheduled three times per day. Over the next six days, the AP documented she administered 18 doses of oxycodone 5 mg (administering two tablets each time). No other nurse administered oxycodone and there was no administration on days the AP did not work.

During an interview, resident 2 stated she did not take any oxycodone. Resident 2 stated she was not experiencing pain; her knee was numb. Resident 2 stated she had gotten constipated from oxycodone and never wanted to take it. Resident 2 stated she just took Tylenol for pain. Resident 2 said during the facility's internal investigation interview they had beat around the bush asking her about her pain and she told them she did not take the pain pills (oxycodone). Resident 2 said they never asked her who she thought it was, but she knew who was taking them. Resident 2 stated nurse 2 told her the AP was the nurse signing the medication record as administering oxycodone. Resident 2 stated the AP worked during the nighttime and often worked two shifts at a time. Resident 2 stated some of the things the AP talked about were off the wall and the AP talked about being able to stay nearby while she traveled to work two shifts in a row.

The AP's agency contract with the facility verified the facility paid additional money for the AP's food and lodging expense.

Resident 3 resided in a skilled nursing facility in the short-term rehabilitation unit. Resident 3's admission diagnosis was a left leg fracture. Resident 3's BIMS score was 15 out 15, indicating intact cognition. Resident 3's MAR included an order for gabapentin (nerve pain medication) 900 mg twice per day and Percocet (oxycodone and acetaminophen combination narcotic pain medication) every six hours as needed. After two days, resident 3's Percocet frequency was increased to every four hours as needed. During the first nine days, resident 3 had been taking Percocet three to four times per day. On day 10, resident 3 had no Percocet. On day 11 and day 12 she had Percocet one time each day.

Resident 3's progress note indicated on day 13 she had no complaints of pain. Nursing had noted resident 3 had been cutting down her Percocet use since receiving education. That same day, the AP documented on the MAR she administered Percocet at 10:30 p.m. and the next morning at 2:37 a.m. The AP returned for the evening shift and documented on the MAR she administered Percocet at 3:17 p.m. and 7:32 p.m. The MAR indicated no other nurse administered Percocet until resident 3 discharged two days later.

In addition, resident 3's progress note indicated at 7:24 a.m., prior to leaving for a doctor's appointment she notified staff her checkbook with credit cards inside was missing from her purse. Resident 3's progress notes indicated staff did not find her missing items after searching.

Review of the facility schedule, the AP worked during the night shift on resident 3's unit and clocked out at 7:21 a.m. the morning resident 3 reported her missing checkbook. The AP's background study records indicated she had a previous history of disqualification related to theft charges.

During an interview, resident 3 stated regarding her medications that if she asked for a pain medication she received it, but she would not know if someone was taking her medications but documenting they gave them to her. Resident 3 stated she mostly requested using pain medication prior to therapy so she could participate in therapy, otherwise she was not using her leg much and did not need it. Resident 3 stated she stopped using pain medication a few days before she discharged, that she was certain of. Resident 3 stated her wallet went missing during her stay at the facility during the night before her doctor's appointment. Resident 3 stated before her doctor's appointment she grabbed her purse and noticed her wallet with her driver's license, credit cards, checkbook and $300 cash were missing. Resident 3 stated she called right away to stop her credit cards and she had to get a new checking account. Resident 3 stated she had not noticed any unusual activity on the accounts, which was smart of the person who stole because they would have been caught.

Resident 4 resided in a skilled nursing facility in the long-term care unit. Resident 4's diagnoses included dementia and received hospice services. Resident 4's assessment indicated her memory was impaired, but she did have clear speech and was usually able to make herself understood. The assessment indicated sometimes she was able to understand direction or questions, but she was unable to answer questions about pain. The assessment indicated resident 4 did not have any behaviors.

Resident 4's MAR included orders for scheduled morphine 5 mg tablet three times per day and 5 mg every hour as needed. Review of three months of MARs indicated the first month on one day resident 4 received an as needed dose of morphine 5 mg administered in the morning by one nurse and in the afternoon received an anti-anxiety medication administered by a different nurse. The AP documented administration of all other as needed doses of morphine on each of the three months of MARs, a total of 27 doses.

The narcotic log indicated the AP removed 11 doses of morphine with no record of administration on resident 4's MAR.

Resident 4 had passed away during the course of the investigation. During an interview, family stated they were unaware of medication diversion concerns in the facility.

Resident 5 resided in a skilled nursing facility in the short-term rehabilitation unit. Resident 5's admission diagnosis was chronic obstructive pulmonary disease exacerbation. Resident 5's BIMS score was 15 out 15, indicating intact cognition. Resident 5's MAR included orders for oxycodone 5 mg every six hours (for back pain) as needed and tizanidine (muscle relaxant)

twice a day as needed. The AP documented she administered five of 10 tablets received from the pharmacy of oxycodone. No other nurse administered oxycodone.

During an interview, resident 5 stated she had a bowel obstruction from taking opioids in the hospital that caused some back pain. Resident 5 stated while she was at the facility, she received therapy and used iced to treat pain; she did not take any pain medication.

The facility internal investigation indicated nurse 2 noticed an administration of oxycodone to resident 2 and went to ask her about needed any bowel medication due to narcotic use. Resident 2 was confused and stated she was not taking any oxycodone. Nurse 2 also observed resident 1's hydromorphone supply low and asked him about his usage, in which he replied he had not been taking hydromorphone. Nurse 2 noted the AP had been the nurse documenting administration of those medications to resident 1 and resident 2. Nurse 2 reported her concerns of drug diversion to the charge nurse (nurse 3). Nurse 3 then reported the concerns of drug diversion to the director of nursing (DON) and administrator. The DON and administrator went to the facility at the end of an evening shift and placed the AP on leave. The DON and administrator interviewed residents about their pain, reviewed as needed controlled medication usage throughout the facility during the time the AP had been working at the facility and interview other staff. Nurse 1 stated resident 1 had only asked for hydromorphone one time, the day he returned from surgery. When asked about his hydromorphone supply with two tablets remaining, nurse 1 stated resident 1 told her he had not been asking for any. The DON and regional nurse reviewed MARs and narcotic logs for patterns of diversion. The internal investigation noted there had been three reports of missing money in addition during the time frame the AP worked. The DON and administrator reported the diversion to law enforcement and the MN board of nursing.

During an interview, nurse 2 stated resident 1 never asked for narcotics after returning from the hospital after shoulder surgery. Resident 2 stated she only used Tylenol and she never took oxycodone because it made her constipated. After reporting the diversion, nurse 2 stated there was a difference noticed when the AP was gone because there were less documented as needed medication administrations. Nurse 2 stated she had interacted with the AP when she worked on the short-term rehabilitation unit and in hindsight there was signs the AP was struggling during narcotic count with increased energy and very talkative, but skin was pale.

During an interview, nurse 1 stated she primarily worked on the short-term rehabilitation units on the night shift. Nurse 1 stated during shift change narcotic counts, her and nurse 2 observed resident 1 and resident 2's supply decrease and neither of them were requesting medications when nurse 1 or nurse 2 worked. Nurse 1 stated resident 1 and resident 2 confirmed they were not taking the narcotic medications. Nurse 1 stated she and nurse 2 reported concerns to the management. Nurse 1 stated when resident 1 first admitted to the facility he was in a lot of pain, after several days his pain improved to where he we was not take oxycodone any more, even before surgery because he was just utilizing Tylenol. Nurse 1 stated resident 1 liked to go to bed at 10:00 p.m. and not be disturbed during the night. Nurse 1 stated resident 2 never

asked for pain medication. Nurse 1 stated resident 2 went to be around 9:00 p.m. or 10:00 p.m. and did not wake up until after 5:00 a.m.

During an interview, the DON stated there was several residents who's as needed medication administration records were concerning, including hospice residents who had not been needing as needed doses, but administered when the AP worked. The DON stated they compared the MARs with the narcotic logs and there were several administrations where the time the AP logged the time between different resident administrations where it would not have been possible for her to walk from part of the building to another unit to administer medications that quickly. The DON stated she completed medication audits after the AP no longer worked at the facility and there were not any other unusual patterns of administration.

During an interview, the administrator stated resident 1 and resident 2 were cognitively intact and could state the exact time they last took any narcotic medication, which were at both of their recent hospital stays and nothing at the facility. The administrator stated they assessed for concern there was diversion of resident's scheduled medications and after pain assessments determined it was likely all residents did receive their scheduled medications.

Three days after being removed from the facility, the AP participated in a 10-panel drug test. However, an article from American Addiction Centers, "How Long Do Drugs Stay In Your System? (Drug Half-Life & Drug Tests)," indicated oxycodone half-life (duration of time for concentration levels to decrease by half) is three to five hours and morphine half-life is one to seven hours.

During an interview, the AP stated the facility leadership accused her of medication diversion when she left the facility on her own accord, but on bad terms because of agency contract issues. The AP said she had already dealt with the MN board of nursing on the allegations, it was done and over with, everything was handled, and she is back to work. The AP stated during the night shift she covered two units and if someone needed a medication she would administer it, go back to her computer to document, administer the next resident's medication, and go back to her computer to document that administration. The AP said all she was asked about was missing medication. The AP said, "That woman never said one thing about money, or whatever is that's allegedly missing."

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;

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: Yes, Resident 2, Resident 3, Resident 5. No, Resident 1 declined, Resident 4 passed away.
Family/Responsible Party interviewed: Yes, Resident 4. Not Applicable for Resident 1, Resident 2, Resident 3, Resident 5.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated the drug diversion, removed the AP from the facility, assessed the residents, reported to law enforcement and to the MN board of nursing.

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
Steele County Attorney
Owatonna City Attorney
Owatonna 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
	00644	A. BUILDING: _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KODA LIVING COMMUNITY	2255 30TH STREET NW OWATONNA, MN 55060

(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 H54267386M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00644	A. BUILDING: _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KODA LIVING COMMUNITY	2255 30TH STREET NW OWATONNA, MN 55060

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2 000	Continued From page 1 are issued for H54267386M, 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 five of six resident(s) reviewed (R1, R2, R3, R4, R5) 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.	