



Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report  
PUBLIC

Facility:

Seminary Home  
906 College Avenue  
Red Wing, MN 55066  
Goodhue County

Report #: H5449013

Date: November 14, 2014

Date of Visit: May 5, 2014  
Time of Visit: 8:15 a.m.- 3:15 p.m.

By: William Nelson, R.N., Special Investigator

- Type of Facility:**
- Nursing Home
  - SLF
  - Hospital
  - HHA
  - ICF/IID
  - Other: \_\_\_\_\_
  - Home Care Provider/Assisted Living
  - Home Care

- Facility Self Report
- Complaint

**Allegation(s):** It is alleged that exploitation occurred when a staff took several residents' narcotic medication.

**An unannounced visit was made at this facility and an investigation was conducted under:**

- Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
- Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
- Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
- Federal Regulations for EMTALA (42 CFR Part 489)
- State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
- State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
- State Licensing Rules for Home Care (MN Rules Chapter 4668)

- State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)  
 State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)  
 State Statutes Chapters 144 and 144A

**Conclusion:**

**Minnesota Vulnerable Adults Act (MN 626.557)**

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

Abuse       Neglect       Financial Exploitation was:

Substantiated     Not Substantiated     Inconclusive    based on the following information:

Based on a preponderance of evidence financial exploitation did occur when the alleged perpetrator (AP) took three residents prescription medications (narcotics) for his/her own use. The AP admitted to taking one Dilaudid, one Oxycontin and one Oxycodone on one occasion from three different residents. The AP admitted to taking multiple doses of Oxycodone from one resident over three months, while working the night shift.

Resident #1 has chronic pain. Resident #1's prescribed narcotics were Oxycontin 20 mg twice a day, Norco 5/325 three times a day and Tramadol 50 mg every six hours as needed. Resident #2's diagnoses include osteoarthritis and generalized pain. Resident #2 prescribed narcotics were Oxycodone 5 milligrams every four hours as needed for pain. Resident #3 has chronic pain. Resident #3's prescribed narcotics were Dilaudid 2 mg tablets, one or two tablets every six hours as needed for pain.

During a staff meeting, the AP was observed to be tired, his/her speech was slurred, and s/he was very slow to answer any questions. Administrative staff met with the AP. During this meeting, the AP admitted to stealing narcotics from the residents' supply and to the use of the narcotics. The AP agreed to a drug screen urinalysis (UA). The UA results were positive for oxycodone, and oxymorphone.

The police report indicated that the police arrived at approximately 7:05 a.m. The officer asked the AP what s/he had ingested. The AP told the police officer that s/he had taken and ingested Oxycodone 5 mg, Dilaudid, 2 mg and Oxycontin unknown dosage from resident #1, resident #2 and resident #3. The AP told the officer that prior to this occurrence s/he had taken Oxycodone from one resident on multiple occasions over the past several months.

The AP refused to be interviewed.

**Mitigating Factors:**

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the  individual(s) and/or  facility is responsible for the

Abuse     Neglect     Financial Exploitation. This determination was based on the following:

The facility had policies and procedures in place addressing the administration and inventory control of narcotics. The AP had received training on the Vulnerable Adult Act and Resident Bill of Rights.

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.

### **Compliance:**

**Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) – Compliance Met**  
The facility was found to be in compliance with Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B). No deficiencies were issued.

**State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Met**  
The facility was found to be in compliance with State Licensing Rules for Nursing Homes (MN Rules Chapter 4658). No state orders were issued.

**State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met**  
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

**State Statutes Chapters 144 & 144A – Compliance Met**  
The facility was found to be in compliance with State Statutes for Chapters 144 & 144A. No state licensing orders were issued.

### **Facility Corrective Action:**

The facility took the following corrective action(s):  
Prior to the site investigation, the facility completed pain assessments on all the residents to identify anyone with poor pain control. Audits were completed on narcotic medication administration, focused on documentation and questionable patterns. The facility had mandatory reviews of policies and procedures on medication administration and documentation. All the nursing staff were re-educated on the Vulnerable Adult Act. The Nursing department had trained all the nurses on how to identify the different signs of drug diversion.

**Definitions:****Minnesota Statutes, section 626.5572, subdivision 9 - Financial exploitation**

"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;

(c) Nothing in this definition requires a facility or caregiver to provide financial management or supervise financial management for a vulnerable adult except as otherwise required by law.

**Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated**

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

**The Investigation included the following:****Document Review: The following records were reviewed during the investigation:**

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> Medical Records                   | <input type="checkbox"/> Care Guide                              |
| <input checked="" type="checkbox"/> Medication Administration Records | <input type="checkbox"/> Treatment Sheets                        |
| <input type="checkbox"/> Facility Incident Reports                    | <input type="checkbox"/> Physician Progress Notes                |
| <input type="checkbox"/> ADL (Activities of Daily Living) Flow Sheets | <input checked="" type="checkbox"/> Laboratory and X-ray Reports |
| <input checked="" type="checkbox"/> Physician Orders                  | <input type="checkbox"/> Social Service Notes                    |
| <input checked="" type="checkbox"/> Nurses Notes                      | <input type="checkbox"/> Meal Intake Records                     |
| <input type="checkbox"/> Activities Reports                           | <input type="checkbox"/> Weight Records                          |
| <input type="checkbox"/> Therapy and/or Ancillary Services Records    | <input checked="" type="checkbox"/> Assessments                  |
| <input type="checkbox"/> Skin Assessments                             | <input type="checkbox"/> Care Plan Records                       |

**Other pertinent medical records:**



Physician interviewed:  Yes  No

Nurse Practitioner interviewed:  Yes  No

Interview with Alleged Perpetrator(s):  Yes  No  N/A Specify: Spoke with AP- Declined interview

Attempts to contact: Date/time: \_\_\_\_\_ Date/time: \_\_\_\_\_ Date/time: \_\_\_\_\_

If unable to contact was subpoena issued:  Yes , date subpoena was issued \_\_\_\_\_  No

Were contacts made with any of the following:

Emergency personnel  Police Officers  Medical Examiner  Other: Specify \_\_\_\_\_

**Observations were conducted related to:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Wound Care                  | <input type="checkbox"/> Medication Pass                   | <input type="checkbox"/> Meals            |
| <input type="checkbox"/> Personal Care               | <input checked="" type="checkbox"/> Dignity/Privacy Issues | <input type="checkbox"/> Restorative Care |
| <input checked="" type="checkbox"/> Nursing Services | <input checked="" type="checkbox"/> Safety Issues          | <input type="checkbox"/> Facility Tour    |
| <input type="checkbox"/> Infection Control           | <input checked="" type="checkbox"/> Cleanliness            | <input type="checkbox"/> Injury           |
| <input type="checkbox"/> Use of Equipment            | <input type="checkbox"/> Transfers                         | <input type="checkbox"/> Incontinence     |
| <input type="checkbox"/> Call Light                  | <input type="checkbox"/> Other: _____                      |   |

Was any involved equipment inspected:  Yes  No  N/A

Was equipment being operated in safe manner:  Yes  No  N/A

Were photographs taken:  Yes  No Specify: \_\_\_\_\_

xc: Division of Compliance Monitoring - Licensing & Certification  
 Minnesota Board of Nursing Home Administrators  
 Minnesota Board of Nursing  
 Red Wing City Police Department  
 Goodhue County Attorney  
 Red Wing City Attorney

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/21/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  SEMINARY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 906 COLLEGE AVENUE RED WING, MN 55066
---	---

(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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p><b>INITIAL COMMENTS</b></p> <p>An abbreviated standard survey was conducted to investigate case #H5449013. Seminary Home is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities.</p> <p>Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p>	F 000		
-------	---	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE 05/30/2014
--	-------	-------------------------

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  00150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/21/2014
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SEMINARY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 906 COLLEGE AVENUE RED WING, MN 55066
---	---

(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5449013. No correction orders were issued.</p> <p>Because you are enrolled in ePOC, your signature is not required at the bottom of the first</p>	2 000		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/30/14



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  00150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/21/2014
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SEMINARY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 906 COLLEGE AVENUE RED WING, MN 55066
---	---

(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	Continued From page 1  page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	2 000		