Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54541703M, H54541702M, H54541720M
Compliance #: H54548435C, H54548436C, H54548390C

Date Concluded: July 12, 2024

Name, Address, and County of Licensee Investigated:
Sandstone Health Care Center
109 Court Avenue South
Sandstone, MN 55072
Pine County

Facility Type: Nursing Home

Evaluator's Name: Holly German, 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 three residents when the AP took the residents medication for personal use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP took narcotic medications from the residents (resident #1, resident #2 and resident #3) for her own personal use. The AP gave the residents their ordered medication and took extra doses for her own use.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the residents' records,

facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures.

Resident #1 resided in a skilled nursing facility. Resident #1's diagnoses included chronic pain syndrome and polyneuropathy (damaged nerves in different parts of the body). Resident #1's care plan included assistance with bed mobility and toileting. Resident #1's assessment indicated she was alert, oriented and independent with an electric wheelchair.

Resident #2 resided in a skilled nursing facility. Resident #2's diagnoses included amputation of a lower limb and obesity. Resident #2's care plan included assistance with medication administration and repositioning. Resident #2's assessment indicated he was alert, orientated and used a wheelchair independently.

Resident #3 resided in a skilled nursing facility. Resident #3's diagnoses included restlessness, agitation, and dementia. Resident #3's care plan included assistance with medication administration and all activities of daily living. Resident #3's assessment indicated she was understood by others at times and was wheelchair bound.

The facility internal investigation indicated nurse #2 noted resident #1 had multiple medication cards in use for the same medication. Upon further inspection, nurse #2 noted repeated medication doses removed for the same dates and times from the medication cards. Nurse #2 notified supervising nurse #1 of her concerns. Nurse #1 began an investigation into the discrepancies. The investigation revealed the AP had removed three unaccounted for controlled medications from resident #1's medication supply, nine unaccounted for controlled medications from resident #2's medication supply, and two unaccounted for medications from resident #3's medication supply.

Resident #1's narcotic logbook indicated the AP removed three tablets of Percocet (a controlled narcotic pain medication), however there were no documented administrations when compared to resident #1's medication administration record (MAR).

Resident #2's narcotic logbook indicated the AP removed nine tablets of Oxycodone (a controlled narcotic pain medication), however there were no documented administrations when compared to resident #2's MAR.

Resident #3's narcotic logbook indicated the AP removed two tablets of Morphine Sulfate (a controlled narcotic pain medication), however there were no documented administrations when compared to resident #3's MAR.

The facility internal investigation indicated the unaccounted-for medications were noted to be missing during a four-month time span. The same document indicated the AP denied taking the medications.

The law enforcement (LE) report indicated the AP denied taking the medications to the LE officer. The report indicated the AP could not provide a good explanation to the LE officer as to why the medications were missing.

The Minnesota Board of Nursing website indicated the AP had prior discipline enforced on her nursing license for theft of controlled substances.

During an interview, nurse #1 stated nurse #2 reported to her concerns she noted in a resident #1's MAR and narcotic log book record regarding unaccounted for medication doses signed out by the AP. Nurse #1 stated she spoke to the AP in regards to the unaccounted for medications and the AP stated she must have made a documentation error. The AP denied taking the medications.

During an interview, nurse #3 stated the AP admitted she took the medication when speaking to the AP on the phone. Nurse #3 stated the AP told her she took medications from three residents. Nurse #3 stated the AP told her the residents always got what they needed, and she signed out additional doses.

During an interview, nurse #2 stated there were multiple staff who voiced complaints about the AP's behavior which included the AP falling asleep frequently on shifts and frequently showing up late to her shifts. Nurse #2 stated she noted a concerning pattern on a resident's medication card, where the AP removed multiple doses from multiple medication cards of the same medication. Nurse #2 stated she noted the AP falling asleep and the AP told nurse #2 she was always tired due to having a low iron blood level. Nurse #2 stated the AP was frequently emotionally volatile.

During an interview, nurse #4 stated multiple staff members voiced concerns about the AP's behavior while on shift. Nurse #4 stated during the AP's last few months of employment, the AP would frequently fall asleep during shifts, would appear to stumble on her own feet at times, and frequently went to her vehicle during her shift. Nurse #4 stated the AP made a statement of mistaking a resident who was walking down the hallway for a bear in the facility. Nurse #4 stated she noted the AP was the only nurse to give out an as needed medication to a resident every time she worked. Nurse #4 stated she brought concerns of the AP's behavior to management staff at least ten times. Nurse #4 stated she believed the AP was taking medications.

During an interview, the AP stated when nurse #1 questioned her about the medication concerns, she told nurse #1 she was not sure why she documented the medication administration wrong and that she did not take the medication. The AP stated she denied taking medications to LE. The AP stated when nurse #3 called her, she admitted that she took medication. During the interview, the AP told the investigator she only took Percocet from one resident. When asked why she previously stated to nurse #3 she took medications from three residents, the AP stated she did not remember other residents or other medications being

involved. The AP stated she did the same thing (took residents medication) at another facility about ten years ago.

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;
(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;

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 #1, Resident #2, Resident #3 interviewed during survey.
Family/Responsible Party interviewed: Not applicable, residents were their own decision maker.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility suspended the AP pending investigation. 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
Pine County Attorney
Sandstone City Attorney
Sandstone 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
	00452	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE HEALTH CARE CENTER	109 COURT AVENUE SOUTH SANDSTONE, MN 55072

(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 #H54541703M, #H54541702M, #H54541720M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.	2 000	No plan of correction is required for this tag.	

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2 000	Continued From page 1 The following correction order is issued for #H54541703M, #H54541702M, #H54541720M, 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	21850		

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21850	Continued From page 2 others. This MN Requirement is not met as evidenced by: The facility failed to ensure three of three residents reviewed (R1), (R2), (R3) were 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		