Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54959906M
Compliance #: H54957322C

Date Concluded: April 18, 2024

Name, Address, and County of Licensee Investigated:
The Emeralds at Grand Rapids
2801 South Highway 169
Grand Rapids, MN 55744
Itasca 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), a facility nurse, financially exploited the resident when the AP did not give a resident his Oxycodone (opioid narcotic pain medication) pill and instead switched the medication for a different non-narcotic medication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP switched out the resident's scheduled Oxycodone pill and instead gave the resident Melatonin (used for sleeping).

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted law enforcement. The AP did not respond to a subpoena. The investigation included review of the resident records, facility internal investigation, personnel files, staff schedules, law enforcement report, and related facility policy and procedures.

The resident resided in a nursing home. The resident's diagnoses included quadriplegia (paralysis of all four limbs). The resident had intact cognition.

The resident's physician order included Oxycodone 10 milligrams (mg) four times a day for pain at 8:00 a.m., 2:00 p.m., 8:00 p.m., and 2:00 a.m. The Oxycodone was to be taken with Tylenol 650 mg four times a day for pain.

The facility's investigation indicated the resident reported to the facility his Oxycodone pill tasted different, during the 2 a.m. medication administration when the AP gave the resident his medication. The resident explained the Oxycodone pill tasted bitter, but recently the pill he had received at 2:00 a.m. did not have a taste. The resident reported this had been going on for a while and the resident noticed an increase in his pain the last couple days. When the resident received the 2 a.m. medication from the AP, he fell asleep and woke up with extreme pain. The resident's doctor told the resident the Oxycodone pill should have a number 10 stamped on it. When the AP gave the resident an Oxycodone pill, the resident spit out his medication and noticed there was no number 10 stamped on the pill. The facility's investigation determined the AP switched out the resident's Oxycodone pill with Melatonin.

During an interview, a nurse stated the resident came to her and asked if there were different types of Oxycodone pills. The resident stated when the AP gave him his Oxycodone pill, it tasted different. The resident removed a tissue from his wheelchair, that contained two pills. The nurse noticed the pills were larger than Oxycodone pills. The nurse stated she brought the pills to leadership. The nurse stated the AP worked with the resident a couple nights later, and again the resident saved his pill. The pill saved was not Oxycodone.

During an interview, leadership stated the resident noticed when the AP gave him the Oxycodone pill at 2 a.m. it tasted different, no bitter taste, and he had increased pain. The resident began spitting out the 2 a.m. medication and kept the medication in a tissue to show a nurse one day. Leadership stated they determined the pill the resident received was Melatonin pill from the facility's stock supply. Leadership stated when the narcotic books and medication administration record was reviewed, it indicated the AP had signed out and gave the medication as ordered, however, the resident did not receive the medication. Leadership stated during the investigation, it was revealed the AP's nursing license was suspended due to narcotic diversion at a different facility.

During an interview, the resident stated he had constant pain in his hands. The resident stated when he received his Oxycodone the pain would go away. The resident stated for several nights he would get his Oxycodone scheduled at 2 a.m. and noticed his pain did not go away. The resident collected several pills given at 2 a.m., and then gave the pills to a nurse. The resident stated he could tell it was a different pill he was getting instead of Oxycodone because the pill tasted different, and there was no number stamped on the pill.

The law enforcement report indicated they were not able to contact the AP and closed the case.

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; 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: Yes.
Family/Responsible Party interviewed: No. Resident was responsible for self.
Alleged Perpetrator interviewed: No. Did not respond to subpoena.

Action taken by facility:
The facility notified the resident’s doctor, suspended the AP during the investigation and notified law enforcement. The AP is no longer employed at 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
Itasca County Attorney
Grand Rapids City Attorney
Grand Rapids 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
	00299	A. BUILDING: _____ B. WING _____	C 03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(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 #H54959906M, 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	No plan of correction is required for this tag.	

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2 000	Continued From page 1 #H54959906M, 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		