Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H55226968M
Compliance #: H55222850C

Date Concluded: February 27, 2024

Name, Address, and County of Licensee Investigated:
Living Meadows Care Center
503 Benzel Avenue Southwest
Madelia, MN 56062
Watonwan County

Facility Type: Nursing Home

Evaluator's Name:
Katie Germann, 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 (R1, R2, and R3) when the AP took the residents Oxycodone (a narcotic pain medication) and replaced it with other medications.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP was witnessed on facility camera footage, taking narcotic medication out of the nursing cart and tampering with the narcotic cards on multiple occasions.

The investigator conducted interviews with facility staff members, including administrative and nursing staff. The investigator contacted law enforcement. The investigation included review of the facility investigation, the police report, resident records, staff records, and facility policies and procedures.

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R1 resided in a nursing home with diagnoses including Parkinson’s disease and chronic pain. The resident’s service plan included assistance with medication administration.

R2 resided in a nursing home with diagnoses including Dementia and chronic pain. The resident’s service plan included assistance with medication administration.

R3 resided in a nursing home with diagnosis including Neuropathic and acute pain. The resident’s service plan included assistance with medication administration.

A facility investigation indicated during a routine count of narcotics it was noted by the facility nurse R2’s oxycodone was tampered with and two of the pills had been replaced with another medication. Upon investigation of the incident, R1 and R3’s oxycodone had also been tampered with and it appeared Oxycodone had been replaced with an unknown tablet. The investigation indicated R2’s oxycodone had been replaced with furosemide (a diuretic medication), R1’s oxycodone had been replaced with baclofen (a muscle relaxant medication), and R3’s oxycodone had been replaced with atenolol (a blood pressure medication). The facility administration reviewed recorded camera surveillance of the nursing medication carts and discovered the AP was observed tampering with residents’ medications. The facility created a timeline of video surveillance from the evening before the medication tampering was discovered. The timeline included observations of the AP taking narcotic medication from the east medication cart and putting it in the west medication cart. A short time later, the AP was observed apply tape to the back of the narcotic card.

A police report indicated the recorded video surveillance showed the AP passing medications from the facility’s west side medication cart. The AP was observed going to the east side medication cart and taking a narcotic medication out of it. The AP dispensed medication out of the narcotic card and was seen tampering with the packaging with tape. The AP was seen bringing something to her mouth with her right hand at one point while the medication was in her sight. The AP was also observed taking out non-narcotic medications and looking at them closely with a flashlight. The AP was seen dispensing narcotic medication and not logging it in the narcotic log per protocol. The police report indicated the AP should not have been taking medication out of the east medication cart when the AP was working on the west medication cart. The facility administration stated the AP could have gotten keys for the east side medication cart from the medication room where they keep the master set of keys for the overnight nurse.

The law enforcement report indicated the AP pled guilty and was convicted of theft of a controlled substance.

When interviewed facility administration stated she was alerted to R1, R2, and R3's oxycodone missing when staff found one of the medication cards had been tampered with. Administration viewed the recorded camera footage and saw the AP tampering with the narcotic medication cards. Administration stated the AP denied taking R1, R2, and R3's oxycodone for her own personal use.

During interview, the AP stated she heard of medications being tampered with and became suspicious after another employee had mentioned it. The AP stated she only went to look in the other medication cart to compare the medications to the cart she was working on. The AP denied taking R1, R2, and R3's oxycodone.

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: No, unable.
Family/Responsible Party interviewed: No
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The AP is no longer employed at the facility.
The facility filed a police report and a report with the Department of Health. The facility also had all the staff who worked with medications drug tested immediately.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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
Watonwan County Attorney
Madelia City Attorney
Madelia Police Department
MN Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00695	A. BUILDING: _____ B. WING _____	C 01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING MEADOWS AT LUTHER - MADELIA	503 BENZEL AVENUE SW MADELIA, MN 56062

(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 #H55226968M and #H55228744M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.	2 000		

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2 000	Continued From page 1 The following correction order is issued for #H55226968M, 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(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the 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. No plan of correction is required for this tag.	21850		