Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H56314844M
Compliance #: H56314802C

Date Concluded: September 16, 2024

Name, Address, and County of Licensee Investigated:
Minnesota Veteran's Home-Luverne
1300 North Kniss Avenue
Luverne, MN 56156
Rock County

Facility Type: Nursing Home

Evaluator's Name: Lissa Lin, RN
Special Investigator

Finding: Not Substantiated

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 the resident when she diverted one dose of his prescribed narcotic medication for her own use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was not substantiated. While the AP failed to follow facility policies and procedures for controlled medication administration, documentation, and disposition when she removed one dose of hydrocodone from an emergency medication kit (e-kit) to correct the resident's prescribed narcotic medication count, there was no indication she took the narcotic for her own use. The resident's missing dose of hydrocodone was found, and the resident was unharmed.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted the resident's family member. The investigation

included review of the resident records, pharmacy records, facility internal investigation, personnel files, staff schedules, and related facility policy and procedures.

The resident resided in a nursing home. The resident's diagnoses included spondylosis (abnormal wearing down of bones and cartilage) and impaired cognition. The resident's care plan indicated he had impaired mobility. His services included medication administration. He received a prescribed narcotic, hydrocodone 5 milligrams (mg) /325 mg, three times daily for moderate pain due to his spondylosis, polyneuropathy and gout. He had periods of confusion and could not always make his needs known.

Review of the facility's internal investigation indicated one morning medications from their main pharmacy were delivered to the wrong area of the building. A nurse brought the medications to the unit where the resident lived and where the AP worked. The nurse told the AP medications had arrived and the AP said she would take care of the e-kit medication delivery. The e-kit was an emergency medication kit containing controlled medications for immediate emergent use. It was not an extra medication source. The e-kit was locked with a red zip-tie device.

The e-kit was supposed to be locked in the medication room when delivered but was left in the report room. Sometime during the day shift, someone placed the e-kit in the designated locked cupboard in the medication room. The AP and two other nurses who worked that shift indicated they did not move the e-kit into the report room or medication room.

That evening, a nurse went to the medication room to complete the shift medication count and discovered the e-kit lock was tampered with and the e-kit was not locked. One dose of hydrocodone was missing from the e-kit, and it had not been signed out according to protocol. The nurse noted entries in the resident's narcotic log were written over or drawn through by the AP. The resident's hydrocodone medication card was reviewed. It had the correct count with 26 doses, but the 26th dose had a punctured foil seal that was taped over. The nurse notified nursing management.

The following day, another nurse in the unit found a clear medication cup containing a single-dose hydrocodone bubble pack with a punctured and taped over foil compartment. It was on a tray with other medications. There was a pill in the punctured compartment. Written on the medication cup was "Found Floor" with the resident's initials. Staff matched the medication card lot number to the missing hydrocodone medication from the e-kit.

Management called the AP as part of their internal investigation. The AP said she did not handle the delivered medications and maybe the missing narcotic pill belonged to another resident with the same initials. Management indicated in their internal investigation the missing hydrocodone pill was not mentioned to the AP in the phone call, and the resident she named did not have a prescription for hydrocodone.

During the AP's interview with management, the AP said she was verbally trained on using the e-kit for extra medications, but she could not recall what staff member trained her. The AP said she removed one hydrocodone pill from the e-kit to correct the resident's narcotic count, then found a hydrocodone pill hanging out of the resident's medication card. She taped the pill back into the bubble pack compartment. She put the e-kit hydrocodone pill into her pocket and planned to let the charge nurse know what happened. Then she placed the pill in a clear medication cup with a note to destroy it but forgot to tell the charge nurse. The AP said at some point she ripped out one page from the narcotic log book because the resident's medication count was wrong, but another nurse instructed her to tape it back into the log book.

The facility provided photographs of the evidence they collected which coincided with their internal investigation.

Review of the AP's competency checklist indicated she completed training on administering medications, checking in delivered medications, locking and counting schedule II – V medications, the emergency drug kit content/supply list, signing out e-kit medications, faxing to the pharmacy and medication destruction.

During an interview, an administrator said the AP openly admitted to taking a hydrocodone pill out of the e-kit because it was an "extra medication kit" and she needed to get the resident's narcotic medication count correct. The administrator said the AP's account of her actions was inconsistent. She had been a nurse for many years but was new to the facility and still in her probation period. The administrator said he was surprised the AP used such poor judgement and tried to cover up a medication error. He did not think the AP's actions were drug diversion because the AP never said she planned to take the hydrocodone for her own use when interviewed by management and the missing pill was found.

During an interview, a nurse said the AP struggled with administering medications and taking direction from other nurses. The AP already had approximately nine medication errors, one involved a narcotic medication, so management moved her to a different section of the facility where a nurse was nearby to work with her. When the missing hydrocodone medication was discovered, the nurse said management asked the AP to meet with them and verify each dose of narcotic medication she had given recently. The AP never met with management; she left the building because her family member just had a car accident. The AP never returned to the facility. Management later interviewed the AP by phone about the medication error incident. The nurse said she was not sure the AP tried to divert the hydrocodone.

During an interview, the AP said her job was to pass medications and that day shift was busy. At the end of her shift when she conducted her hydrocodone medication count for the resident it was off by one dose. She recounted his hydrocodone medication and was still short one dose. She crossed out the final count numbers several times in the resident's narcotic log book. The AP said she went to the "extra med tote", took out one dose of hydrocodone and wrote a medication report. She went back to her medication cart and rechecked the resident's

hydrocodone cards and saw one of the hydrocodone bubble packs was open and the pill was halfway out of the compartment. The AP said she taped the pill back into the bubble pack and completed her now correct count. She placed the hydrocodone pill from the e-kit in a medication cup and locked it in the top drawer of the medication cart. The AP said she planned to tell the nurse what she did but forgot because she was busy checking in delivered medications and then her shift was over. The AP said she did not ask another nurse to help her with her medication count because the registered nurse was unavailable, and she did not feel comfortable going for help. The AP said there were two medication kits, an extra medication tote and an emergency kit. She took the hydrocodone pill from the smaller kit with the zip tie. (This matched the facility's internal investigation description of the emergency medication kit.) The next morning the AP found the initialed medication cup on her medication cart. She did not know who placed it there. She assumed the cup with its contents belonged on the memory care medication cart and placed it there. The AP said she did not know there was a hydrocodone tablet in the medication cup. The AP said management called her about the resident's hydrocodone medications and suspended her during their investigation. She said she already had several medication errors and because she was still on probation the facility let her go. The AP said she never took resident medication for her own use and the pill was accounted for.

During an interview, the resident's family member said she was called right away about the medication incident. The staff were not sure if the resident received his hydrocodone medication late, or received an extra dose, but he remained at his baseline with no signs of increased pain. The family member said it sounded like a training issue and she had no concerns. The resident liked living there.

In conclusion, the Minnesota Department of Health determined financial exploitation was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

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;

Vulnerable Adult interviewed: No, difficulty speaking and cognition issues.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility suspended the AP and conducted an internal investigation. The AP no longer works for the facility. Nursing staff received re-education on medication administration and documentation.

Action taken by the Minnesota Department of Health:
The facility was found to be in 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

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00411	A. BUILDING: _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME - LUVERNE	1300 NORTH KNISS AVENUE LUVERNE, MN 56156

(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 #H56314844M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The	

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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000	state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the evaluators findings are the Suggested Method of Correction and the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN, WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	