DEPARTMENT OF HEALTH

# Office of Health Facility Complaints Investigative Report
PUBLIC

**Facility Name:**
Vista Prairie at Goldfinch Estates

**Facility Address:**
850 Goldfinch Street

**Facility City:**
Fairmont

| **State:** | **ZIP:** | **County:** |
|---|---|---|
| Minnesota | 56031 | Martin |

**Report Number:**
HL23692004, HL23692005, HL23692006, HL23692007, HL23692009, HL23692010, HL23692011, HL23692012

**Date of Visit:**
April 17, 2017 and April 18, 2017

**Time of Visit:**
8:00 a.m. to 6:30 p.m. and 8:00 a.m. to 4:30 p.m.

**Date Concluded:**
November 20, 2017

**Investigator's Name and Title:**
Casey DeVries, RN, Special Investigator

☒ **Home Care Provider/Assisted Living**

## Allegation(s):

It is alleged that multiple clients were financially exploited when the alleged perpetrator (AP) stole medications from the clients.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

## Conclusion:

Based on a preponderance of evidence, financial exploitation occurred when the alleged perpetrator (AP) took medications from multiple clients for his/her personal use. The AP admitted to taking medications from multiple clients over a two-month period of time.

Client #1 received medication administration services from the home care provider according to a service plan. Client #1 had a physician's order for oxycodone extended release 10 milligrams (mg) daily as needed for pain. Client #1 routinely requested the medication each morning.

Client #2 received medication administration services from the home care provider according to a service plan. Client #2 had a physician's order for hydrocodone-acetaminophen 5/325 mg to be administered three times daily.

Client #3 received medication administration services from the home care provider according to a service plan. Client #3 had a physician's order for tramadol 50 mg to be administered three times daily.

Client #4 received comprehensive services from the home care provider according to a service plan. Client #4 was independent with medication administration and kept medications in his/her apartment. Client #4 had a physician's order for oxycodone 5-325 mg four times daily as needed for pain.

Client #5 received medication administration services from the home care provider according to a service plan. Client #5 had a physician's order for Novolog insulin to be administered three times daily.

Client #6 received medication set up services for non-controlled medications from the home care provider according to a service plan. Client #6 was independent with controlled medications and kept them in his/her apartment. Client #6 had a physician's order for oxycodone 5 mg for pain and diazepam 2 mg for anxiety.

Client #7 received medication administration services from the home care provider according to a service plan. Client #7 had a physician's order for Novolog insulin to be administered three times daily and for Lantus insulin to be administered two times daily.

Client #8 received medication administration services from the home care provider according to a service plan. Client #8 had a physician's order for acetaminophen-codeine 300/30 mg twice daily as needed for pain.

Client #9 received medication administration services from the home care provider according to a service plan. Client #9 had a physician's order for hydrocodone-acetaminophen 5/325 mg three times daily as needed for pain and for alprazolam 0.5 mg three times daily as needed for anxiety.

Client #10 received medication administration services from the home care provider according to a service plan. Client #10 had a physician's order for tramadol 50 mg six times daily as needed for pain.

Client #11 received medication administration services from the home care provider according to a service plan. Client #11 had a physician's order for tramadol 50 mg to be administered twice daily.

Document review and observations made during the on-site investigation indicated the home care provider had central storage located on the medication carts where staff dispensed medications for clients who receive administration assistance. The pharmacy delivered some of the medications weekly in hard plastic cassettes, with eight individual slots to separate doses. When staff removed a dose, a plastic seal broke on the backside, which staff then discard. On-duty staff kept medication cart keys in their possession. Staff double-locked controlled substances in the cart, and two staff counted them at every shift change.

During an interview, a nurse stated a pharmacist alerted the facility of a problem by calling to report tramadol belonging to Client #3, which the facility had returned to the pharmacy due to a physician order change, was different from what the packaging indicated and appeared to be caffeine tablets. The discovery prompted the nurses to check cassettes within the medication cart for other clients who had tramadol ordered. The nurses found that all of cassettes which contained tramadol appeared tampered with. The

nurses expanded the search to include all controlled substances, and found multiple other medications tampered with. In addition, two clients who self-administered their own controlled substances reported their personal supplies were taken.

A police report indicated the facility called police for a suspected drug diversion. The report revealed police interviewed and searched the alleged perpetrator (AP), whom facility management had identified to be one of several staff with recent access to the medications. Police discovered the AP had three small medication cups in his/her pants pocket containing client medications. During an interview with police, the AP admitted s/he had taken medications from Client #1, Client #2, Client #3, Client #9, and Client #11 over a two-month period, and replaced the original medications in the pill cassettes with other medications, some of which s/he brought from home, sometimes caffeine pills. The AP stated s/he took the clients' medications for personal use. The report indicated a search of the AP's car found medications and medication packaging belonging to Client #4, Client #5, Client #6, and Client #7. In addition, Client #8 and Client #10's medications were later reported to have been affected as well.

A review of client records revealed the facility contacted a consultant pharmacist to immediately inspect all medications in the medication carts, and nursing conducted assessments of all clients known to be affected. The facility notified the client's primary care providers of the diversion.

During interviews, Client #2, Client #4, Client #5, Client #7, Client #9, and Client #11 stated they did not recall feeling effects related to changes in their medications. Client #1 stated s/he may have been affected, but could not say for sure, as s/he has arthritis and associated increased pain during that time with weather changes. Client #6, Client #8, and Client #10 stated they were affected, due to lack of usual relief from pain. Client #3 stated s/he suffered from insomnia and was hospitalized twice for multiple complaints during the two months the AP was taking medications, although hospital providers were unable to identify a cause for the way Client #3 was feeling.

The facility terminated the AP from employment.

The AP was unable to be reached for interview.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☐ Neglect ☒ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

**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 home care provider had policies in place to address financial exploitation. The AP's personnel file

showed the AP received training in regards to the home care bill of rights, vulnerable adult, and abuse prevention policies.

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:**

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 for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

**Compliance Notes:**

**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.

**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:**

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] ADL (Activities of Daily Living) Flow Sheets
- [x] Service Plan

**Other pertinent medical records:**

- [x] Police Report

**Additional facility records:**

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: None

Were residents selected based on the allegation(s)? ○ Yes ○ No ◉ N/A

Specify:

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A

Specify: Client #2 and client #3 were out of the facility during the on-site investigation.

**Interviews: The following interviews were conducted during the investigation:**

Interview with reporter(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact reporter, attempts were made on:

| Date: | Time: | Date: | Time: | Date: | Time: |
|---|---|---|---|---|---|
| | | | | | |

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents? ○ Yes ◉ No

Total number of resident interviews: Eleven

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

**Tennessen Warnings**

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Seven

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ◉ No ○ N/A Specify: _____

Attempts to contact:

| Date: | Time: | Date: | Time: | Date: | Time: |
|---|---|---|---|---|---|
| | | | | | |

If unable to contact was subpoena issued: ◉ Yes, date subpoena was issued June 21, 2017 ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

**Observations were conducted related to:**

- [x] Nursing Services
- [x] Infection Control
- [x] Medication Pass
- [x] Cleanliness
- [x] Meals
- [x] Facility Tour

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: _____

cc:

**Health Regulation Division - Home Care & Assisted Living Program**

**The Office of Ombudsman for Long-Term Care**

**Fairmont Police Department**

**Martin County Attorney**

**Fairmont City Attorney**

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Certified Mail Number: 7015 1660 0000 4149 8174

October 20, 2017

Mr. Morris Knopf, Administrator
Vista Prairie At Goldfinch Estates
850 Goldfinch Street
Fairmont, MN 56031

RE: Complaint Number HL23692002, HL23692003, HL23692004, HL23692005, HL23692006, HL23692007, HL23692008, HL23692009, HL23692010, HL23692011, and HL23692012

Dear Mr. Knopf :

A complaint investigation (#HL23692002, HL23692003, HL23692004, HL23692005, HL23692006, HL23692007, HL23692008, HL23692009, HL23692010, HL23692011, and HL23692012) of the Home Care Provider named above was completed on October 20, 2017, for the purpose of assessing compliance with state licensing regulations. At the time of the investigation, the investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these regulations. These state licensing orders are issued in accordance with Minnesota Statutes Sections 144A.43 to 144A.482.

State licensing orders are delineated on the attached State Form. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by."

A written plan for correction of licensing orders is not required. Per Minnesota State Statute 144A.474 Subd. 8(c), the home care provider must document in the provider's records any action taken to comply with the correction order. A copy of this document of the home care provider's action may be requested at future surveys.

A licensed home care provider may request a correction order reconsideration regarding any correction order issued to the provider. The reconsideration must be in writing and received within 15 calendar days. Reconsiderations should be addressed to:

Ms. Michelle Ness, Assistant Director
Office of Health Facility Complaints
Minnesota Department of Health
P.O. Box 64970
St. Paul, MN 55164-0970

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Health Regulations Division
Supervisor Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201- Fax: (651) 281-9796

Enclosure

cc: Home Health Care Assisted Living File
Martin County Adult Protection
Office of Ombudsman
MN Department of Human Services

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H23692 | A. BUILDING: _____ B. WING _____ | C 10/20/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VISTA PRAIRIE AT GOLDFINCH ESTATES | 850 GOLDFINCH STREET FAIRMONT, MN 56031 |

| (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 |
|---|---|---|---|---|
| 0 000 | Initial Comments<br><br>*****ATTENTION******<br><br>HOME CARE PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>On April 17 and 18, 2017, a complaint investigation was initiated to investigate complaint #HL23692002, HL23692003, HL23692004, HL23692005, HL23692006, HL23692007, HL23692008, HL23692009, HL23692010, HL23692011, and HL23692012. At the time of the survey, there were 112 clients that were receiving services under the comprehensive license.<br><br>The following correction orders are issued related to complaints #HL23692004, HL23692005, HL23692006, HL23692007, HL23692009, HL23692010, HL23692011, and HL23692012. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 1441.474 subd. 11 (b) (1) (2). | |
| 0 325 SS=E | 144A.44, Subd. 1(14) Free From Maltreatment<br><br>Subdivision 1. Statement of rights. A person who receives home care services has these rights: | 0 325 | | |

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| 0 325 | Continued From page 1<br>(14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the licensee failed to ensure that eleven of eleven clients (C1, C2, C3, C4, C5, C6, C7, C8, C9, C10, and C11) was free from maltreatment (financial exploitation) when a staff member took medications from the eleven clients, on multiple occasions.<br><br>This practice resulted in a level 2 violation (a violation that did not harm the client's health or safety but had the potential to have harmed a client's health or safety) and is issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive).<br><br>The findings include:<br><br>Observations made during the onsite investigation on April 17, 2017 at 12:04 p.m., indicated the facility had central storage medication carts, from which staff dispense active medications for clients who receive medication administration assistance. The pharmacy delivers some of the medications weekly in hard plastic cassettes with eight individual slots to separate doses. When staff remove a dose, a plastic seal is broken on the backside, which staff then discard. On-duty staff kept medication cart keys in their possession. Staff double lock narcotic medications in the cart, and two staff count them | 0 325 | | |

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| 0 325 | Continued From page 2<br>at every shift change.<br><br>C1's record was reviewed. C1 received medication administration services from the licensee according to a service agreement dated June 20, 2016. C1 had a physician's order for oxycodone extended release 10 milligrams (mg) daily as needed for pain dated February 6, 2016. Review of C1's March 2017 medication administration record (MAR) revealed C1 routinely requested the medication each morning. A document titled, "MD Visit/Contact," dated March 15, 2017, indicated C1's oxycodone tablets were tampered with and switched out for famotidine (an over the counter antacid medication.) The document indicated the tampering took place over a two-month period.<br><br>C2's record was reviewed. C2 received medication administration services from the licensee according to a service agreement dated June 20, 2016. C2 had a physician's order for hydrocodone-acetaminophen 5/325mg, dated February 28, 2017. Review of C2's March 2017 MAR revealed C2 received the medication on a scheduled basis three times daily. A document titled, "MD Visit/Contact," dated March 15, 2017 indicated C2's hydrocodone-acetaminophen tablets were tampered with and switched out for caffeine pills, which were available over the counter. The document indicated the tampering took place over a two-month period.<br><br>C3's record was reviewed. C3 received medication administration services from the licensee according to a service agreement dated September 1, 2016. C3 had a physician's order for tramadol 50mg dated March 8, 2017. Review of C3's March 2017 MAR revealed C3 received the medication on a scheduled basis three times | 0 325 | | |

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| 0 325 | Continued From page 3<br>daily. A document titled, "MD Visit/Contact," dated March 14, 2017 indicated C3's tramadol tablets were tampered with and switched for caffeine pills. The document indicated the tampering took place over a two-month period.<br><br>C4's record was reviewed. C4 received comprehensive services from the licensee according to a service agreement dated February 20, 2017. C4 was independent with medication administration and kept medications in his/her apartment. A document titled, "MD Visit/Contact," dated March 16, 2017 indicated an empty blister pack that had contained oxycodone 5/325mg tablets and belonging to C4 was found in resident assistant (RA)-N's car.<br><br>C5's record was reviewed. C5 received medication administration services from the licensee according to a service agreement dated February 6, 2017. C5 had a physician's order dated March 7, 2017, for Novolog insulin to be administered three times daily. A document titled, "MD Visit/Contact," dated March 16, 2017 indicated two loaded insulin syringes, labeled with C5's name, were found in RA-N's car.<br><br>C6's record was reviewed. C6 received medication set up services for non-controlled medications from the licensee according to a service agreement dated Decemeber 16, 2016. C6 self-administered his/her own controlled medications and kept them in his/her apartment. A document titled, "MD Visit/Contact," dated March 16, 2017 indicated C6 noticed a bottle of oxycodone 5mg containing three tablets was missing, a bottle of diazepam 2mg tablets containing an unknown amount of tablets was missing, and an additional bottle of oxycodone 5mg tablets contained the wrong medication. C6 | 0 325 | | |

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| 0 325 | Continued From page 4<br>also stated s/he had an old bottle of hydrocodone-acetaminophen 10/300mg in his/her apartment, which was missing.<br><br>C7's record was reviewed. C7 received medication administration services from the licensee according to a service agreement dated June 20, 2016. C7 had a physician's order dated February 17, 2017 for Novolog insulin to be administered three times daily and for Lantus insulin to be administered two times daily. A document titled, "MD Visit/Contact," dated March 16, 2017 indicated two loaded syringes, labeled with C7's name, were found in RA-N's car.<br><br>C8's record was reviewed. C8 received medication administration services from the licensee according to a service agreement dated March 7, 2017. C8 had a physician's order for acetaminophen-codeine 300/30mg dated November 7, 2016. A document titled, "MD Visit/Contact," dated March 17, 2017 indicated twenty tablets of acetaminophen-codeine 300/30mg in a bottle were taken and replaced with Excedrin (an over the counter headache relief medication.)<br><br>C9's record was reviewed. C9 received medication administration services from the licensee according to a service agreement dated November 14, 2016. C9 had a physician's order for hydrocodone-acetaminophen 5/325mg dated October 25, 2016. C9 had a physician's order for alprazolam 0.5mg dated September 7, 2016. Review of C9's March 2017 MAR revealed C9 requested the hydrocodone-acetaminophen medication ten times for pain. No alprazolam was administered. A document titled, "MD Visit/Contact," dated March 15, 2017 indicated C9's alprazolam was tampered with and switched | 0 325 | | |

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| 0 325 | Continued From page 5<br>for metroprolol succinate (a prescription heart medication), and C9's hydrocodone-acetaminophen was tampered with and switched for caffeine pills. The document indicated the tampering took place over a two-month period.<br><br>C10's record was reviewed. C10 received medication administration services from the licensee according to a service agreement dated November 28, 2016. C10 had a physician's order for tramadol 50mg dated September 26, 2016. C10's March 2017 MAR revealed C10 requested the medication five times for pain. A document titled, "MD Visit/Contact," dated March 15, 2017 indicated C10's tramadol was tampered with and switched for caffeine pills. The document indicated the tampering took place over a two-month period.<br><br>C11's record was reviewed. C11 received medication administration services from the licensee according to a service agreement dated February 6, 2017. C11 had a physician's order for tramadol 50mg dated July 2, 2015. Review of C11's MAR revealed C11 received the medication on a scheduled basis two times daily. A document titled "MD Visit/Contact," dated March 15, 2017 indicated C11's tramadol was tampered with and switched for caffeine pills. The document indicated the tampering took place over a two-month period.<br><br>An untitled document, dated March 14, 2017, indicated a facility nurse received a phone call that day from a pharmacy regarding C3's medication, tramadol, which the facility had sent back to the pharmacy on March 10, 2017 because C3's physician order had changed. The pharmacy alerted the facility the medication was | 0 325 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H23692 | A. BUILDING: _____ B. WING _____ | C 10/20/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VISTA PRAIRIE AT GOLDFINCH ESTATES | 850 GOLDFINCH STREET FAIRMONT, MN 56031 |

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| 0 325 | Continued From page 6<br><br>different from what the packing indicated, and appeared to be caffeine tablets. The document indicated the facility nurse then checked all of the cassettes within the medication cart of all other clients who had tramadol ordered. The nurse found all of the tramadol cassettes appeared to have been tampered with. The document indicated nursing continued to check other controlled substance cassettes and found they had been tampered with as well.<br><br>A police report dated March 14, 2017, indicated the facility called police for a suspected drug diversion. The report revealed police interviewed and searched RA-N, whom facility management identified to be one of several staff with recent access to the medications. Police discovered RA-N had three small medication cups in his/her pants pocket containing one pill of Carbidopa/Levodopa and two other unidentifiable pills. During an interview with police, RA-N admitted s/he had been taking medications from five clients (C1, C2, C3, C9, and C11) over a two-month period, and was replacing the original medications in the pill cassettes with medications s/he brought from home, which were sometimes caffeine pills. The report indicated C10's medication was tampered with as well. RA-N stated s/he took the medications for his/her own use. The report indicated a search of RA-N's car on March 15, 2017 revealed empty medication packages and medications identified as belonging to C4, C5, C6, and C7. The facility updated police on March 17, 2017 that medications belonging to C8 also appeared to have been tampered with as well. Police arrested RA-N and forwarded their findings to the county attorney for criminal charges.<br><br>During an interview with Registered Nurse (RN)-A | 0 325 | | |

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|---|---|---|---|---|
| 0 325 | Continued From page 7<br>on April 18, 2017 at 2:05 p.m., RN-A stated that RA-N replaced the medications she took from clients with medications which matched the appearance of the medications s/he took, so other staff would not be alerted to the diversion.<br><br>An undated policy titled, "Home Care Bill of Rights", indicated all staff receive training about the bill of rights and are expected to adhere to them.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 325 | | |