Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303918664M
Compliance #: HL303916124C

Date Concluded: February 5, 2024

Name, Address, and County of Licensee Investigated:
Vista Prairie at Garnette Gardens
511 S Dekalb St
Redwood Falls, MN
Redwood County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Lena Gangestad, 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 five residents when she diverted controlled substances including opioid pain medications.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The investigation identified a pattern of documentation indicative of drug diversion for four out of the five residents reviewed extending over a three month period.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator interviewed three residents who still resided at the facility. The investigation included review of five resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigation included an onsite visit.

The investigation reviewed residents' medical records over a four month period and referred to below as months #1 through month #4.

The AP
The AP worked at the facility as an unlicensed caregiver whose duties included medication administration. The AP's job duties gave her access to residents' controlled medications. The facility's schedule and payroll indicated the AP primarily worked evening shift.

During random audits of prescribed controlled substances, the facility found discrepancies in the AP's medication passes for five residents. The discrepancies included the following controlled substances as tracked in the facility's narcotic book:

- Lorazepam (a benzodiazepine for anxiety)
- Norco (a combination of hydrocodone, an opioid, and acetaminophen for pain relief)
- Oxycodone (an opioid for pain relief)
- Tramadol (a synthetic opioid pain reliever)

The investigation identified a pattern which indicated the AP diverted from four of the five residents identified in the random audits of controlled substances over the course of three months. Near the end of month #3, the AP no longer worked at the facility.

Resident #1
The resident #1 's diagnoses included anxiety disorder and bipolar disorder. The service plan for resident #1 included assistance with medication administration.

The electronic medication administration record (EMAR) indicated the resident was prescribed lorazepam 0.5 milligram (mg) one tablet by mouth every two hours PRN (as needed).

During month #3 the narcotic book indicated the AP removed PRN Lorazepam from resident #1's supply on one occasion. However, there was no corresponding record of administration in the EMAR.

The investigation did not identify a pattern of documentation of drug diversion regarding resident #1.

Resident #2
The resident #2 diagnoses included dementia and restless legs syndrome. The service plan for resident #2 included assistance with medication administration.

During the second half of month #1 the EMAR indicated resident #2's medications included:

- Norco one tablet every eight hours
- Norco one tablet daily on during the evening shift

During the second half of month #1 the EMAR indicated the AP documented giving PRN Norco 10 out of the 11 times it was administered the whole month. The same document indicated resident #2 did not require PRN Norco on most days the AP was not working. Although a scheduled Norco dose was scheduled during the evening shift, the EMAR indicated all of the PRN doses administered by the AP were time stamped for the evening shift.

On the last day of month #1 and continuing for all of month #2 the EMAR indicated the APs medications included the following medication:

- Norco one tablet by mouth every two hours PRN

On the last day of month #1, the EMAR indicated the AP documented administering PRN Norco three times. The same documented the AP was the only medication passer to give this medication on this day.

During month #2 the EMAR indicated the AP documented giving PRN Norco approximately 90 times. The same document indicated all other medication passers documented giving PRN Norco a total of seven times combined for all of month #2.

During month #3 the EMAR indicated resident #2's pain medications were changed and included:

- Oxycodone 5 mg one tablet by mouth every six hours, which was scheduled at 8:00 a.m., 12:00 p.m., and Bedtime
- Oxycodone 5 mg one tablet by mouth every two hours PRN

During month #3 the narcotic book indicated the AP was the only medication passer to remove the PRN oxycodone for a total of eight times. The EMAR included six occasions during month #3 the AP documented administrating the PRN oxycodone.

During month #3 the facility conducted random audits and identified discrepancies regarding resident #2's controlled substances, which included two instances the AP documented in the narcotic book removing oxycodone from resident #2's supply, but the AP did not document administration of the oxycodone in the EMAR.

The last day the AP documented passing medications for resident #2 occurred during month #3, which was also the last day any medication passers documented giving PRN oxycodone that month.

During month #4, the AP did not work at the facility. The EMAR indicated resident #2 did not receive PRN oxycodone during month #4.

Resident #3

The resident #3 lived in an assisted living facility and was diagnosed with low back pain and rheumatoid arthritis. The service plan for resident #3 included assistance with medication administration.

The EMAR indicated resident #3's medications included:

- Oxycodone 5 mg one tablet at bedtime
- Oxycodone 5 mg one tablet three times a day PRN with instructions to only give between 5:00 a.m. to 3:00 p.m. and to not give a second dose at bedtime

During month #1 the EMAR indicated the PRN oxycodone was administered 16 times with the AP documenting 12 of those times usually at the beginning of the evening shift.

During month #2 the EMAR indicated the AP was the sole medication passer to document giving the PRN oxycodone. The AP documented this more than 15 times.

During month #3 the EMAR indicated the PRN oxycodone was administered 12 times with the AP documenting 11 of those times usually at the beginning of the evening shift.

During month #3 the narcotic book indicated the AP documented removing PRN oxycodone from resident #3's supply 16 times on one page. The EMAR covering the same time indicated the AP documented administrating six of those occasions.

During month #3 the facility conducted random audits and identified discrepancies regarding resident #3's controlled substances, which included multiple instances the AP documented in the narcotic book removing oxycodone from resident #3's supply, but the AP did not document administration of the oxycodone in the EMAR.

The last day the AP documented passing medications for resident #3 occurred during month #3, which was also the last day any medication passers documented giving PRN oxycodone that month.

During month #4, the AP did not work at the facility. The EMAR indicated resident #3 did not receive PRN oxycodone during month #4.

Resident #4

Resident #4's diagnoses included chronic left knee pain. The service plan for resident #4 included assistance with medication administration.

The EMAR indicated resident #3's medications included:

- Tramadol 50 mg one tablet three times a day PRN

During month #1 the EMAR indicated PRN tramadol was documented as administered approximately 25 times. All but two of these occasions was documented by the AP.

During month #2 the EMAR indicated the AP was the sole medication passer to document giving the PRN tramadol. The AP documented this 15 times.

During month #3 the EMAR indicated the AP was the sole medication passer to document giving the PRN tramadol. The documented this more than 20 times.

During month #3 the facility conducted random audits and identified discrepancies regarding resident #4's controlled substances. The narcotic book indicated the AP documented removing PRN tramadol from resident #4's supply. The audit found more than 10 occasions the AP documented removing PRN tramadol in the narcotic book for which there was no corresponding EMAR documentation during the months #2 and #3.

The last day the AP documented passing medications for resident #4 occurred during month #3, which was also the last day any medication passers documented giving PRN oxycodone that month.

During month #4, the AP did not work at the facility. The EMAR indicated resident #4 did not receive PRN tramadol during month #4.

Resident #5

The resident #5's diagnoses included chronic pain. The service plan for resident #5 included assistance with medication administration.

The EMAR indicated resident #5's medications included:

- Tramadol 50 mg one tablet by mouth at bedtime
- Tramadol 50 mg two tablets by mouth twice a day PRN and included the instruction to wait 4 hours between PRN doses

During month #1 the EMAR indicated the AP was the sole medication passer to document giving PRN tramadol. The AP documented giving the medication more than 10 times.

During month #2 the EMAR indicated the AP documented giving the PRN tramadol more than 20 times. The EMAR indicated there was one occasion when another medication passer gave the PRN tramadol during all of month #2. On one day the AP documented giving the two PRN tramadol in less than two hours even though the instructions specifically stated to wait four hours between PRN doses.

During month #3 the EMAR indicated the AP was the sole medication passer to document giving the PRN tramadol. The AP documented give the PRN tramadol more than 20 times.

During month #3 the facility conducted random audits and identified discrepancies regarding resident #5's controlled substances, which included multiple instances the AP documented in

the narcotic book removing tramadol from resident #5's supply. The audit found more than 15 occasions the AP documented removing PRN tramadol in the narcotic book for which there was no corresponding EMAR documentation during the months #2 and #3.

The last day the AP documented passing medications for resident #5 occurred during month #3, which was also the last day any medication passers documented giving PRN tramadol that month.

During month #4, the AP did not work at the facility. The EMAR indicated resident #5 PRN tramadol one time during the entire month.

Interviews
During an interview, a management staff member stated medication errors were discovered by the nurse during random audits, prompting further investigation. It was found over two months, the AP recorded controlled PRN medications in the narcotic book but failed to document them in the EMAR. This issue affected 5 out of the 9 residents living there. The management staff confirmed the AP was aware of the requirement to document in both the narcotic book and the EMAR, considering her more than five years of working at the facility. According to the narcotic book, the count was correct, but there was uncertainty about the actual administration and receipt of the medications by the residents. The management staff member said the AP was placed on leave during the internal investigation, which began near the end of month #3. The AP did not return to work and was terminated in the beginning of month #4.

During an interview, the AP confirmed she had been working there for almost ten years and acknowledged a medication error had been brought to her attention and stated she was unaware of not entering them into the computer system, which happened on quite a few instances. She stated the lapse occurred due to picking up extra shifts and working more than usual leading to fatigue. The AP acknowledged she was supposed to document in both the narcotic book and the computer system [EMAR]. Depending on the residents' symptoms, she stated she had the authority to decide when the residents needed PRN pain medication. She stated she kept residents informed of the pain medications available to them and had been coached to assess residents' pain more comprehensively or to offer alternative such as warm packs or redirection before resorting to medications.

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:
(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:
(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or
(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.
(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, attempts to interview unsuccessful
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility started an internal investigation as a result of random audits, notified the police, and terminated the AP’s employment.

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
Redwood County Attorney
Redwood Falls City Attorney

Redwood Falls Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30391	A. BUILDING: _____ B. WING _____	C 01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE AT GARNETTE GARDENS	511 DEKALB STREET REDWOOD FALLS, MN 56283

(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 On January 3, 2024, the Minnesota Department of Health initiated an investigation of complaint HL303918664M/HL303916124C. The following correction order is issued, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure four of five resident reviewed (R2, R3, R4 and R5) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an indivdual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	