Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H50637205M
Compliance #: H50633320C

Date Concluded: April 17, 2024

Name, Address, and County of Licensee Investigated:
St. Anthony Park Home
2237 Commonwealth Ave
St. Paul, MN 55106
Ramsey 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), an agency nurse, financially exploited a resident when the AP removed Oxycodone (narcotic pain medication) from the resident's medication card and replaced it with a different medication that was not a narcotic pain medication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The facility identified tampering of seven medication cards containing Oxycodone (opioid narcotic) tablets. The foil on the back of the medication cards was torn and/or cut, the Oxycodone tablet removed, replaced with a non-narcotic medication, and the foil was taped over. In a two-week period, the AP had access to those medication cards and had a pattern of dispensing most of the as needed Oxycodone to resident #1, resident #2, resident #3, and resident #5. In addition, the AP had actions taken against her license from another state.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator contacted the AP, law enforcement, the staffing agency that employed the AP, and family members. The investigation included review of the residents' records, facility internal investigation, personnel files, staff schedules, law enforcement report, federal surveyor notes, and related facility policy and procedures.

Resident #1 resided in a nursing home. Resident #1's provider order included Oxycodone 5 milligrams (mg) every four hours as needed for moderate to severe pain.

Resident #2 resided in a nursing home. Resident #2's provider order included Oxycodone 5 mg two times a day and every four hours as needed for pain.

Resident #3 resided in a nursing home. Resident #3's provider orders included Oxycodone 2.5 mg three times a day (every eight hours) as needed for moderate to severe pain.

Resident #4 resided in a nursing home. Resident #4's provider orders included Oxycodone 2.5 mg three times (every eight hours) a day as needed for pain.

Resident #5 resided in a nursing home. Resident #5's provider orders included Oxycodone 2.5mg every four hours as needed for pain.

The facility investigation indicated a nurse discovered and reported to leadership tampering of a resident's medication card containing Oxycodone. The foil on the back of the medication card had been cut and taped over with the Oxycodone tablet replaced with either Metoprolol or Midodrine (both used to treat high blood pressure). Leadership conducted an immediate audit of all narcotic medication cards in the facility and found the same tampering with six additional cards of which potentially affected resident #2, and resident #4. Resident #2's medication card containing Oxycodone had 15 areas of foil cut and taped over and replaced with a different medication. An additional four areas had been cut with the tape and medication removed, indicating resident #2 may have received four doses of the incorrect medication. Review of resident #4's Oxycodone 2.5 mg tablet medication card indicated six areas where the foil was torn and taped, with the Oxycodone replaced with a different medication. Resident #4's medication card had 10 additional areas where the individual foil had been cut with the tape and medication removed, indicating resident #4 may have received 10 doses an incorrect medication. Staff notified resident #2 and resident #4's provider that the residents may have received incorrect medications. The provider directed staff to monitor the residents for any adverse effects.

The investigation indicated leadership initially identified three nurses that had access to the affected medication carts including the AP. Upon further investigation, the facility determined the AP was responsible for the tampering of the residents' Oxycodone medication cards. The AP had access to the medication carts where the medication was stored and a pattern dispensing as needed Oxycodone to residents more frequently than other staff.

The investigation indicated; multiple staff stated the AP had suspicious activities specifically with narcotics. Identified activities included setting up medications for administration behind the nurse's station and not at the medication cart according to facility process, leaving the floor for extended periods of time, and leaving the facility during her shift to pick up personal medications from the pharmacy. During the facility investigation the AP declined to answer the questions about the reported suspicious activity during her shifts.

Review of resident #1's medication administration record (MAR), indicated in one day, the AP gave resident #1, four of the total six doses of Oxycodone 5 mg given to resident #1 for one month.

Review of resident #2's MAR, indicated in nine days, the AP gave resident #2 six of the total 11 Oxycodone doses resident #2 received for one month.

Review of resident #3's MAR, indicated during a four-day period, the AP gave resident #3 six of a total of 13 doses of Oxycodone given to resident #3 in one month. The AP was the only staff to sign off multiple doses given to resident #3 in one day. In addition, instead of the Oxycodone dispensed to resident #3 every eight hours as ordered, the AP documented giving resident #3 the three total doses for one day, every three to five hours.

Review of resident #5's MAR, indicated over four days, the AP gave resident #5, 12 of the total 19 doses of Oxycodone given in one month. The AP was the only staff to sign off multiple doses given to resident #5 in a day. In addition, the AP dispensed one dose of Oxycodone to resident #5 during a night shift when the AP was not scheduled to work.

During an interview, a nurse stated one day the AP was working and after the AP went on break the AP appeared impaired with slurred speech, dropping papers, and just "weird" behavior.

During an interview, another nurse stated she noticed the AP signed off more Oxycodone than any other nurse, which she considered a "red flag." The nurse stated she observed the AP with a bag containing bottles of pills.

During an interview, leadership stated during the investigation they found the AP had access to the second and third floor carts with the tampered Oxycodone medication cards and the AP was giving more as needed Oxycodone to resident #1, resident #2, resident #3, and resident #5. Leadership stated they reviewed two other nurses, both who were ruled out for the tampering of the Oxycodone medication cards. Leadership stated when interviewed, the AP stated resident #1's son requested the AP give resident #1 pain medication for his legs, however there was no documentation of resident #1 having pain in his legs. In addition, the AP stated resident #3 was screaming in pain one entire shift. Leadership stated when interviewed other staff stated resident #3 was not screaming out and there was no documentation of resident #3 screaming out with pain. Administrative staff stated the AP was from a staffing agency and was

asked not to return to the facility. Administrative staff stated when the AP left, no further incidents or concerns of narcotic diversion were identified through audits.

During an interview, the staffing coordinator from the staffing agency stated the AP stopped communicating with the agency when they questioned the AP about the incident at the facility. The staffing coordinator stated the AP was no longer employed at the staffing agency.

During an interview, the AP stated she worked at the facility for a couple months and that her main job duty was medication administration. The AP denied taking or replacing Oxycodone medication with blood pressure medication.

During an interview, resident #1's family member stated he would not ask staff to give resident #1 pain medication because resident #1 was able to ask for it himself.

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. All residents were attempted but did not reach.
Family/Responsible Party interviewed: Family interviews were completed for resident #1, resident #3, resident #4 and resident #5. Family members for resident #2 was attempted but did not reach.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation, notified family members or residents, notified the residents' physicians, and changed procedures for narcotic counting and administration. The facility notified a pharmacy consultant to review possible side effects from receiving the wrong

medication and notified law enforcement. The facility notified the staffing agency and requested the AP not return to 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
Ramsey County Attorney
St. Paul City Attorney
St. Paul Police Department
Minnesota Board of Nursing
Drug Enforcement Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00997	A. BUILDING: _____ B. WING _____	C 02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY PARK HOME INC	2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108

(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 #H54227168M/#H54222946C, 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		

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2 000	Continued From page 1 H50637205M / H50633320C, 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 seven of seven 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	No plan of correction is required for this tag.	