Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H53444622M
Compliance #: H53445063C

Date Concluded: September 13, 2024

Name, Address, and County of Licensee Investigated:
Fairview Care Center
702 10th Ave NW
Dodge Center, MN 55927
Dodge County

Facility Type: Nursing Home

Evaluator's Name:
Lisa Coil, 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, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The alleged perpetrator financially exploited the resident when they took two resident's oxycodone (opioid) medication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The alleged perpetrator was responsible for the maltreatment. The alleged perpetrator documented in resident #1 and residents #2 electronic medication administration records (EMAR) and the narcotic records that she withdrew as needed narcotic medications. However, the pattern in which the alleged perpetrator removed medications from the residents' narcotic supply and statements from the residents indicated she did not administer the narcotics to them.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted resident 1, resident 2, and resident 1's family member. The investigation included review of resident records, facility internal investigation,

facility narcotic log records, the alleged perpetrator personnel file, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator reviewed surveyor records from the onsite complaint visit.

The alleged perpetrator was employed at the facility for approximately five-and-a-half weeks which coincided with the time reviewed below.

The EMAR, which was computerized and time-stamped, for resident #1 and resident #2 were reviewed for a time covering approximately five weeks.

Resident #1 had an order for oxycodone 5 milligrams, one tablet every 4 hours as needed for pain during all five weeks under consideration.

Resident #2 had an order for oxycodone 5 milligrams, one tablet every 3 hours as needed for pain during part of the five weeks under consideration. Resident #2's order was changed to 5 milligrams, one or two tablets every 4 hours as needed for pain during part of the five weeks under consideration.

Resident #1 and resident #2 did not live on the same unit within the facility so their medications were not stored in the same medication carts. There were shifts the alleged perpetrator was assigned to the medication cart with resident #1's oxycodone and other shifts the alleged perpetrator was assigned to the medication cart with resident #2's oxycodone. At times, the alleged perpetrator was assigned to one medication cart during one shift and then assigned to the other medication cart for the next shift on the same day.

Week One

A review of the facility assignment sheets indicated the alleged perpetrator worked four days during week one. During week one, the alleged perpetrator worked three times as charge nurse and one time on resident #1's medication cart.

Resident #1's EMAR indicated oxycodone was documented as administered three times during week one. Two of those occasions were documented by the alleged perpetrator and one was documented by another caregiver.

Resident #1's EMAR indicated the first time the alleged perpetrator administered resident #1's oxycodone was when she was assigned as charge nurse on Monday evening. The alleged perpetrator administered oxycodone to resident #1 again on Wednesday evening when she was assigned to the medication cart.

A review of the facility narcotic logbook indicated the alleged perpetrator signed out a second oxycodone tablet on Wednesday evening for resident #1, but the EMAR did not show the medication was administered by the alleged perpetrator or any other caregiver. The narcotic logbook is a handwritten paper document and does not have a computerized timestamp.

Resident #2's EMAR indicated oxycodone was not ordered during week one.

Week Two

A review of the facility assignment sheets indicated the alleged perpetrator worked all seven days during week two and two of those days included a double shift, working the evening shift and continued working through the night shift. During week two, the alleged perpetrator worked four times as charge nurse and five times on resident #1's medication cart. The alleged perpetrator was not scheduled to work on resident #2's medication cart during week two.

Resident #1's EMAR indicated oxycodone was documented as administered eight times during week two. All eight occasions were documented by the alleged perpetrator. No other caregiver documented administering resident #1 oxycodone during week two.

Resident #1's EMAR indicated during week two, the alleged perpetrator documented administering oxycodone on four days, five different shifts.

Resident #1's EMAR indicated the alleged perpetrator administered oxycodone two times on Thursday evening shift, one time on Sunday evening shift, two times on Monday evening shift, and two times on Tuesday evening shift. During these four shifts, the alleged perpetrator was assigned to resident #1's medication cart. The alleged perpetrator also administered oxycodone one time on Tuesday overnight shift while she was assigned as charge nurse.

A review of the facility narcotic logbook indicated the alleged perpetrator signed out an oxycodone tablet at 1:30 a.m. on Wednesday for resident #1, but the EMAR did not show the medication was administered by the alleged perpetrator or any other caregiver.

Resident #2's EMAR indicated oxycodone was documented as administered three times during week two. None of those occasions were documented as administered by the alleged perpetrator.

Week Three

A review of the facility assignment sheets indicated the alleged perpetrator worked five days during week three, two of those days included a double shift. During week three, the alleged perpetrator worked two times as charge nurse, two times on resident #1's medication cart, and three times on resident #2's medication cart.

Resident #1's EMAR indicated oxycodone was documented as administered four times during week three. All four occasions were documented by the alleged perpetrator. No other caregiver documented administering resident #1 oxycodone during week three.

Resident #2's EMAR indicated two tables of oxycodone were documented as administered four times during week three. All four occasions were documented as administered by the alleged

perpetrator. No other caregiver documented administering resident #1 oxycodone during week three.

During week three, the alleged perpetrator documented giving oxycodone on three consecutive days.

- On Saturday resident #2's EMAR indicated the alleged perpetrator documented administering two oxycodone tablets three times between the day and evening shift, while assigned to his medication cart.
- On Sunday resident #'2 EMAR indicated the alleged perpetrator documented administering two oxycodone tablets one time on the day shift, while assigned to his medication cart.
- On Sunday, resident #1's EMAR indicated the alleged perpetrator documented administering oxycodone twice on the evening shift, while assigned to her medication cart.
- On Monday resident #1's EMAR indicated the alleged perpetrator documented administering oxycodone twice on the evening shift, while assigned to her medication cart.

The alleged perpetrator did not document administering oxycodone while she was assigned as charge nurse during week three.

A review of the facility narcotic logbook indicated the alleged perpetrator signed out two oxycodone tablets for resident #2 on Sunday day shift, but the EMAR did not show the medication was administered by the alleged perpetrator or any other caregiver.

The alleged perpetrator was the only caregiver who administered oxycodone for the entire week for both resident #1 and resident #2.

Resident #2's EMAR indicated after the Sunday day shift no other caregivers documented administering oxycodone until the alleged perpetrator returned to resident #2's medication cart nearly two weeks later (see Week Five).

Week Four

A review of the facility assignment sheets indicated the alleged perpetrator worked four days during week four. During week four, the alleged perpetrator worked one time as charge nurse and three times on resident #1's medication cart. The alleged perpetrator was not scheduled to work on resident #2' medication cart during week two.

Resident #1's EMAR indicated oxycodone was documented as administered seven times during week four. Five of those occasions were documented by the alleged perpetrator. The two remaining times were documented by two other caregivers on two separate days.

Resident #1's EMAR indicated the alleged perpetrator administered oxycodone two times on Thursday evening shift, two times on Tuesday evening shift, and one time on Wednesday evening shift. During all three of those shifts, the alleged perpetrator was assigned to resident #1's medication cart. The alleged perpetrator did not document administering oxycodone while she was assigned as charge nurse during week four.

Resident #2's EMAR indicated no caregiver documented giving resident #2' oxycodone the during week four.

Week Five

A review of the facility assignment sheets indicated the alleged perpetrator worked three days during week five, two of those days included a double shift. During week three, the alleged perpetrator worked one time as charge nurse, two times on resident #1's medication cart, and two times on resident #2's medication cart.

Resident #1's EMAR indicated oxycodone was documented as administered three times during week five. All of those occasions were documented by the alleged perpetrator. No other caregiver documented giving resident #1 oxycodone during week five.

Resident #1's EMAR indicated the alleged perpetrator documented administering oxycodone three times on Sunday between the day and evening shift, while assigned to the medication cart. Additionally, no caregiver documented giving oxycodone to the end of the month plus seven days into the next month, following the last administered dose from the alleged perpetrator.

Resident #2's EMAR indicated two tablets of oxycodone were documented as administered four times during week five. Three of the four times were documented by the alleged perpetrator as administered on Saturday between the day and evening shift. The fourth oxycodone was administered by another caregiver on the night shift following the alleged perpetrator's day/evening shift. Following these four administrations, resident #2 did not receive any further oxycodone. Resident #2 discharged three days later.

The alleged perpetrator did not document administering oxycodone while she was assigned as charge nurse during week five.

Both resident #1's and resident #2's EMAR indicated the alleged perpetrator did not participate in any further medication passes for either resident after this Sunday.

During an interview, resident #1 stated her pain was not extreme and she could have Tylenol or oxycodone to relieve the pain. Resident #1 stated she remembered telling staff she only wanted to use oxycodone very seldom and did not want to be on it very long because it caused her to hallucinate when she used it prior. Resident #1 stated staff usually suggested Tylenol and that was what she used. When asked if she thought she took oxycodone six times in three days,

resident #1 stated she did not feel like she had done that. When asked if she thought she took oxycodone 20 times in 23 days, resident #1 stated “absolutely not, I think I would have been out of it.”

During an interview, resident #1’s family member stated resident #1 had an extremely high pain tolerance. The family member stated resident #1 usually took Tylenol for pain if she took anything at all. The family member stated it was not very frequently resident #1 would take oxycodone for pain. When asked if they thought resident #1 took oxycodone six times in three days, the family member stated that seems high when resident #1 did not have a lot of pain. When asked if they thought resident #1 took oxycodone 20 times in 23 days, the family member stated they did not believe resident #1 took that many and stated they do not see that as a characteristic of resident #1 at all.

During an interview, resident #2 stated he had a lot of pain the first week at the facility and was using scheduled Tylenol and oxycodone. Resident #2 stated he would have to ask for the oxycodone or staff would ask him what his pain level was and whether he wanted oxycodone or not. Resident #2 stated after about the first week his pain went away enough where the Tylenol was handling it well. Resident #2 stated he did not take oxycodone for the last one-in-a-half to two weeks of his stay at the facility, at least not to his knowledge.

During an interview, when asked how the total number of pills were determined to be involved in the incident, the manager, who was also a nurse, stated she figured out the number of pills popped out of the medication bubble pack along with the number of electronic medication administrations signed off by the alleged perpetrator. When asked if resident #1 and resident #2’s electronic medication administration records were compared to the narcotic logbook the manager stated “no.” The manager stated it was suspicious the number of times the alleged perpetrator administered the pain medications. The manager stated the alleged perpetrator became defensive during interview and claimed she must be the only nurse doing pain assessments.

During an interview, the alleged perpetrator stated resident #1 obtained a compound fracture from a fall, had a significant amount of pain, and took her pain medication consistently. The alleged perpetrator stated she asked resident #1 every night she worked if resident #1 was having pain, if resident #1 wanted something for the pain, and would give medication accordingly. The alleged perpetrator stated resident #1 was not as cognitive as resident #2 and she did not feel resident #1 could say if she did or did not take pain medication. The alleged perpetrator stated she almost never worked down resident 2’s hall and did not know his exact medication regimen. The alleged perpetrator stated resident #2 had aggressive wound treatments, had a lot of pain, and was taking oxycodone consistently. The alleged perpetrator stated she would administer pain medication to resident #2 prior to doing his wound treatments. The alleged perpetrator stated resident #2 maybe did not realize she was asking him about his pain, but she was under the impression he knew she was. The alleged perpetrator stated resident #2 was cognitive, but he did not look at every pill he was given. The alleged

perpetrator stated they (resident #1 and resident #2) are vulnerable adults and there is still brain fog, you cannot take them for 100%. The alleged perpetrator denied taking the medication for her own use.

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.
3
Vulnerable Adult interviewed: Yes, Resident #1, Resident 2.
Family/Responsible Party interviewed: Yes, Resident #1’s.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated the drug diversion, removed the alleged perpetrator from the facility, and reported the concern to law enforcement. The facility re-educated staff on medication management/pain management.

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
Dodge County Attorney
Dodge Center City Attorney
Dodge Center Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00103	A. BUILDING: _____ B. WING _____	C 08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER	702 10TH AVENUE NORTHWEST DODGE CENTER, MN 55927

(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 #H53444622M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders	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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00103	A. BUILDING: _____ B. WING _____	C 08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER	702 10TH AVENUE NORTHWEST DODGE CENTER, MN 55927

(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	Continued From page 1 are issued for #H53444622M, 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	far left column entitled "ID Prefix Tag." The 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." 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.	
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	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00103	A. BUILDING: _____ B. WING _____	C 08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER	702 10TH AVENUE NORTHWEST DODGE CENTER, MN 55927

(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
21850	Continued From page 2 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. 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 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	See Public Report for details.	