Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H53445341M **Date Concluded:** September 24, 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: Inconclusive

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 residents when the alleged perpetrator signed out narcotic pain medications from the locked narcotic box and did not record administering them to residents.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was inconclusive. The investigation demonstrated a discrepancy between what controlled substances the alleged perpetrator removed from residents' supplies and what was administration. However, it could not be determined if maltreatment occurred.

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

narcotic log records, the alleged perpetrator personnel file, and related facility policy and procedures.

A concern arose regarding the alleged perpetrator who repeatedly removed controlled substances, which included narcotic pain medications and benzodiazepines, from residents' supplies without subsequent documentation in the electronic medication administration record (EMAR) for multiple residents, which led to an investigation.

A comparison of the facility's controlled substances narcotic books and the respective EMARs indicated the alleged perpetrator had removed controlled substances from 15 different residents, with at least one instance of failing to document administration of the medication in the resident's EMAR over the course of five consecutive months. The investigation identified more than 50 occasions involving the alleged perpetrator.

The medications involved included the following:

- Hydromorphone tablets and liquid
- Lorazepam tablets and liquid
- Oxycodone tablets
- Morphine sulfate liquid

During an interview, the alleged perpetrator stated she worked the night shift and passed all the medications during her shift. The alleged perpetrator stated there were two medication carts and two sets of keys, one for each medication cart, which had the narcotic keys on them. The alleged perpetrator stated she was the only one who had access to the medication carts during the night shifts she worked. When asked if she felt like there were times she signed out narcotic medications but did not document them on the residents EMAR, the alleged perpetrator stated she had always been very good at that and did not think she had a medication error in 20 years. The alleged perpetrator stated she made a note on her report sheet regarding giving a resident an as needed pain medication so she could report it off to the next shift. The alleged perpetrator stated she usually wrote a progress note in the resident chart also. When told she signed out more than 55 narcotic medications from the log record which were not documented as administered on residents EMARs, the alleged perpetrator stated she could not believe that and could not explain it. The alleged perpetrator further stated she thought a lot of it was her mind had not been good at focusing on work related to personal family matters.

During an interview, the manager, who is also a nurse, stated she compared every entry signed by the alleged perpetrator in the narcotic record book to the residents corresponding EMAR. The manager stated she produced a slightly different number because the alleged perpetrator may have inadvertently documented on the wrong day. The manager stated there were non-narcotic, scheduled medication the alleged perpetrator forgot to document as administered as well. The manager stated she reviewed the alleged perpetrator's report sheets, but most were not dated so there was no way to compare them to the narcotic log record or resident EMARs.

The manager stated the alleged perpetrator said the medications signed out of the narcotic log record were given to residents. The manager stated during interviews, other staff said the alleged perpetrator was distracted, needed multiple reminders, and would fall asleep at the computer while documenting.

A review of the alleged perpetrator's employee records showed the facility had discussed medication errors with the alleged perpetrator in past years, but no recent medication errors were documented. The alleged perpetrator's employee record did not include documentation indicating the facility had identified the discrepancy of the alleged perpetrator's removal of controlled substances and subsequent documentation for the five months reviewed prior to the initiation of this investigation.

In conclusion, the Minnesota Department of Health determined financial exploitation was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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;
(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: Yes, one resident.
Family/Responsible Party interviewed: Yes, for one resident.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The alleged perpetrator is no longer employed at the facility.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, 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.

You may also call 651-201-4200 to receive a copy via mail or email.

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.

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
	00103	A. BUILDING: _____ B. WING _____	C 09/24/2024

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 #H53445341M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

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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		