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

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** H16066704M
**Compliance #:** H15869577C

**Date Concluded:** February 21, 2025

**Name, Address, and County of Licensee Investigated:**

St. Croix Hospice
1001 South Pokegama Avenue Suite D
Grand Rapids, Minnesota 55744
Itasca County

**Facility Type:** Hospice

**Evaluator's Name:** Nicole Myslicki, 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 the client when the AP took the client's narcotic medication.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP could be seen on surveillance video footage filling a syringe with the client's liquid morphine and placing it in a syringe supply box, then leaving the nursing office with the box. The AP admitted to law enforcement to taking one syringe of liquid morphine.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted law enforcement and the client's assisted living facility. The investigation included review of the client's hospice record, death record, agency

internal investigation, incident report, personnel files, assisted living facility documents, and related facility policy and procedures.

The client received services from the hospice agency at her assisted living facility. The client's diagnoses included Alzheimer's disease, dementia, and shortness of breath. The client's services included nursing visits. The client's assessment indicated the agency provided medication management and instruction.

The client's record included an order for morphine concentrate 100 milligrams (mg) per 5 milliliters (ml) oral solution, give 0.25 ml by mouth every two hours as needed for moderate to severe pain or shortness of breath.

An internal investigation indicated the agency received a report of an alleged drug diversion. The agency placed the AP on administrative leave and started the investigation. The agency completed an interview with the AP who admitted to removing one syringe from the facility. The syringe contained morphine from the client's morphine bottle. The AP told the agency she destroyed the medication by flushing it down the toilet after realizing she had the syringe.

An internal investigation completed by the assisted living facility indicated the count of morphine (a narcotic pain-relieving medication) had been off in the narcotic logbook. The assisted living facility nurse and AP reported the count was not correct to make 30 ml. The AP stated the bottle of morphine was empty. The licensed assisted living director (LALD) verified the bottle had been empty and verified the medication count; 23 ml were drawn up for medication set up. The assisted living facility completed a narcotic count, compared the syringes with the narcotic logbook and discovered 7 ml morphine were unaccounted for. The investigation also included watching video footage. Footage from the first day showed the AP put a filled syringe in the syringe supply box. Video footage from about a week later showed the AP appeared to have taken a total of three syringes. At one point, the AP took a filled syringe back out from the syringe box and plunge it back into the morphine bottle. The assisted living facility contacted the hospice agency and informed them of the situation. The assisted living facility reported the diversion to law enforcement.

Video footage showed the AP entered the nursing office at the client's assisted living facility. A facility nurse unlocked a cabinet, removed the client's bottle of morphine, and handed it to the AP. The AP looked at the packaging box, then placed it at the facility nurse's desk and left the room while the facility nurse pulled out the narcotic logbook. A short time later, the AP returned to the nursing office with a syringe supply box. The facility nurse gave the morphine bottle back to the AP. The AP removed the bottle from its packaging and started drawing up the medication from the bottle into syringes, capping the syringe, then placing it on the desk. The AP drew up 10 filled syringes with a small amount of liquid morphine in the syringe, consistent with a prescribed dosing, and place them onto the desk. Then the AP took an empty syringe out of the box, drew up nearly a full syringe of morphine and looked over at the facility nurse. The AP placed the morphine-filled syringe back into the syringe supply box and tucked it behind the

packaging bag with empty, unused syringes, while the facility nurse's attention was elsewhere. The AP then covered the syringe in the box with the bag of syringe caps. The AP put the bottle of morphine back into its packaging box. The facility nurse counted the syringes and signed with the AP signed in the narcotic log, but did not verify the liquid remaining amount within the morphine bottle. The AP left the nursing office with the syringe supply box containing the filled syringe, and the facility nurse locked the bottle of morphine back into the cabinet.

The client's narcotic record indicated 10 syringes of 0.25 ml of morphine were removed from the full 30 ml supply for medication set up. Additional medication set up prior to the next AP hospice visit, indicated the remaining supply of morphine was 17.5 ml.

About one week later, the client's morphine order changed to morphine concentrate 100 mg per 5 ml oral solution, 0.25 ml by mouth scheduled every two hours for pain or shortness of breath, and 0.25 ml by mouth every hour as needed for pain or shortness of breath.

Video footage from the same day the client's morphine order changed, showed the AP entered the nursing office with a syringe supply box. The facility nurse removed the client's morphine from the locked cabinet and handed it to the AP. The morphine was a new supply. The AP removed the packaging seal, and placed the syringe plug adapter into the new bottle of morphine. The AP began drawing up syringes of morphine, capping each one after filling, and placing them on the desk. The AP drew up 22 filled syringes with a small amount of liquid morphine in the syringe, consistent with a prescribed dosing. When the facility nurse received a phone call and turned toward his computer, the AP drew up nearly a full syringe of morphine, placed it at the bottom of the box of the syringe supply box, removed the bag of empty, unused syringes from the box and placed them on the counter. The AP attempted to close the syringe supply box, the top did not stay closed, but the side flaps remained closed. The AP drew up a second partially filled syringe of morphine and placed it in the syringe supply box. The AP then put the bag of empty, unused syringes back into the syringe supply box, covering the two filled syringes. The AP resumed filling morphine syringe doses for the client, placing them on the desk with the others. The AP held the morphine bottle up in the air and looked at the dosing window, then drew up another syringe and placed it on the desk. Then, while the facility nurse took another call, the AP reached back into the box, pulled out the full syringe of morphine, uncapped it, and pushed some liquid back into the morphine bottle until the client's dosing remained in the syringe and added it on the desk with the others. The AP looked at the morphine bottle dosing window again, drew a couple more syringes of morphine and placed them on the desk. After filling 36 syringes, the AP shook the bottle but could not get enough out, so she removed the stopper to draw up enough. She then drew up a couple more syringes and placed them on the desk. As the facility nurse turned away from the AP after taking the filled syringes on the desk, the AP took the second filled syringe she placed in the supply box, plunged contents back into the morphine bottle and placed the syringe on the desk. The AP filled a few syringes for the client's dosing and placed them on the desk. A total of 42 morphine syringes were drawn for medication set up. The facility nurse made a call, and the AP drew one last syringe. She placed it on the desk away from the other syringes. While the facility nurse

looked at the syringes, the AP capped the remaining syringe on the desk near her, placed it in the syringe supply box she came with, and closed the box. The AP waited in the nursing office until the LALD came to the medication room, reviewed the bottle of morphine and narcotic logbook. The AP left the nursing office with the box.

The medication set up of 42 doses would have been 10.5 ml of morphine, out of the 17.5 ml remaining supply. The morphine supply should have had 7 ml remaining.

The client's ALF medication administration record indicated the client did not miss any doses of morphine due to the diversion.

During an interview, a facility nurse stated the agency nurses normally drew up the medication into syringes, then the facility nurse would verify, label, and place the syringes into the medication carts for the caregivers to dispense. Regarding the first day, the AP drew up the syringes. The facility nurse remembered the morphine bottle being about 1 ml short but thought that could have been from dripping. About one week later, the AP had been filling up the syringes again while the facility nurse did the math. The facility nurse discovered they were going to be 7 ml short, so he notified the LALD.

During an interview, the facility LALD stated a different nurse had been there who ran out of syringes. Running out of syringes was the reason the AP came to the facility the second day. The AP stated the agency would replace the facility the syringes they gave them to fill. When the LALD explained that to the AP, she tried to grab the box, but the AP became defensive and grabbed the box quickly. The AP held the box the rest of the time but did take some out of the box before she left. Management staff reviewed video footage and found the AP filled a syringe then put it in the box. They also watched video footage from the second day and observed the AP take a filled syringe and plunge it back into the bottle after she saw the bottle had run out. During their investigation, they also ensured the client did not go without her medication, she had been comfortable, and no harm was done.

During an interview, the hospice agency's associate general counsel (AGC) stated they were made aware of medication concerns from the assisted living facility's administration. The morphine count had been off, and they reviewed their video footage. The hospice agency placed the AP on administrative leave before starting an investigation. They reviewed the facility's video footage and their medical records. Upon reviewing video footage, they believed the AP took one syringe on the first day in concern. On a second day about one week apart, she filled syringes with intent to remove them from the facility. During a meeting with the AP, she did confirm she took a syringe filled with morphine from the client's medication bottle. The AP took it home with her. The AP stated when she realized she had it, she flushed the medication down the toilet. The AP did not document the incident in the record or follow up with her supervisor. The AP also denied trying to take filled syringes on the second date.

During an interview, the client's family member stated the hospice agency did not inform her of the client's diverted medication. Someone at the assisted living facility mentioned something about the medication, but the family member just wanted to make sure the client did not have pain.

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;

**Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):**

(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The AP did not direct an erroneous order, direction, or care plan.

(2) The facility was in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

**Vulnerable Adult interviewed**: No. The resident is deceased.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: No. The AP declined to interview.

**Action taken by facility:**
The agency completed an investigation. The AP is no longer employed by the agency.

**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.

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
Aitkin County Attorney
Aitkin City Attorney
Aitkin Police Department
Minnesota Board of Nursing

Minnesota State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**01/10/2025** |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **St Croix Hospice** | **1001 S POKEGAMA AVE STE D , GRAND RAPIDS, Minnesota, 55744** |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| 40000 | Initial Comments<br><br>The Minnesota Department of Health investigated an allegation of maltreatment, complaint H16066704M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.<br><br>The following correction order is issued for H16066704M, tag identification 40400. | 40000 | | |
| 40400 | HANDLING OF PATIENTS' FINANCES AND PROPERTY<br><br>CFR(s): 4664.0040 Subp. 3-4<br><br>Subp. 3.<br><br>Security of patient property.<br><br>A licensee must not borrow a hospice patient's property, nor in any way convert a hospice patient's property to the licensee's possession, except in payment of a fee at the fair market value of the property.<br><br>Subp. 4.<br><br>Gifts and donations.<br><br>Nothing in this part precludes a licensee or its staff from accepting bona fide gifts of minimal value or precludes the acceptance of donations or bequests made to a licensee that are exempt from income tax under section 501(c) of the Internal Revenue Code of 1986.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>The facility failed to ensure one of one clients reviewed (C1) was free from maltreatment.<br><br>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. | 40400 | | |

Office of Primary Care and Health Systems Management

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | | |