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

# Office of Health Facility Complaints Investigative Public Report

**Maltreatment Report #:** H5628014M **Date Concluded:** October 22, 2020

**Name, Address, and County of Licensee Investigated:**
MN Veteran's Home Silver Bay
56 Outer Drive
Silver Bay, MN 55614
Lake County

**Facility Type: Nursing Home** **Investigator's Name:** Peggy Boeck, RN
Special Investigator

**Finding: Substantiated, individual responsibility**

**Nature of Visit:**

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.

**Allegation(s):**

It is alleged: The Alleged Perpetrator (AP) financially exploited residents when she stole residents' narcotic pain medications for personal use.

**Investigative Findings and Conclusion:**
Financial exploitation was substantiated. The alleged perpetrator was responsible for the maltreatment. The AP admitted to stealing narcotic pain medications belonging to several residents during an interview with law enforcement and again while interviewed by Minnesota Department of Health (MDH) surveyors.

Video from the facility medication room showed the AP removing narcotic pain medications from resident supplies, but not giving the medication to residents. On 15 occasions, the video showed the AP remove narcotic pain medication from resident supply and keep the medication on her person. The AP documented each narcotic medication that she removed from residents'

supplies and falsely documented that she administered the narcotic medication to the residents.

The investigation included interviews with facility staff, including administrative staff and nursing staff. The investigator contacted law enforcement and family members. The investigator reviewed resident records of all potential victims, facility policies, and the personnel file of the AP.

Resident #1 lived at the facility due to diagnoses that included Alzheimer's disease and received hydrocodone/acetaminophen (a narcotic pain medication) 5 – 325 milligrams (mg) every six hours as needed (PRN) for pain.

Resident #2 lived at the facility due to diagnoses that included dementia, arthritis, and low back pain. Resident #2 received oxycodone (a narcotic pain medication) 5 mg four times per day and PRN for pain.

Resident #3 lived at the facility due to diagnoses that included dementia and chronic pain. Resident #3 received hydromorphone (a narcotic pain medication) 8 mg PRN before dressing changes and PRN for pain.

Resident #4 lived at the facility due to diagnoses that included Alzheimer's disease osteoarthritis of the knee, and dorsalgia (pain of the upper back). Resident #4 received oxycodone 5 mg four times per day and every four hours PRN for pain.

Resident #5 lived at the facility due to diagnoses that included dementia, dorsalgia, and sacrococcygeal disorders (injury and pain of the tailbone). Resident #5 received methadone (a narcotic pain medication) 2.5 mg at bedtime for pain.

Resident #6 lived at the facility due to diagnoses that included Alzheimer's disease, gout, and chronic pain. Resident #6 received a fentanyl patch (a long acting narcotic pain patch placed on the skin) 25 micrograms (mcg) applied every three days for pain.

Resident #7 lived at the facility due to diagnoses that included dementia and spinal stenosis (a narrowing of the spaces within the spine that can put pressure on the nerves that travel through the spine). Resident #7 received hydromorphone 4 mg every hour PRN and methadone 2.5 mg every 12 hours PRN for pain.

Resident #8 lived at the facility due to diagnoses that included dementia, chronic pain, osteoarthritis, and fractures of right leg/ lumbar vertebrae (lower back). Resident #8 received methadone 10 mg three times per day for pain and morphine (a narcotic pain medication) 30 mg every hour PRN for pain.

Resident #9 lived at the facility due to diagnoses that included Alzheimer's disease and osteoarthritis. Resident #9 received hydromorphone 2 mg ever hour PRN for pain and methadone 2.5 mg at bedtime for pain.

Several months before the incident, a nurse practitioner informed the director of nursing that she noticed one employee, the AP, gave more PRNS to residents than other employees. The director of nursing looked into medication administration records and noticed that the AP failed to conduct pain assessments before giving narcotic pain medications and failed to try other pain relieving interventions before giving narcotic pain medications. The director of nursing gave the AP a letter of expectation and monitored the AP's medication administration. The AP's use of PRNs went down for two months, but then started going up again.

One day the director of nursing monitored video surveillance of the medication room and saw the AP, take a narcotic pain medication out of Resident #8's supply and put it into her mouth.

The director of nursing placed the AP on investigatory leave and began an investigation. She compared narcotic records with medication administration records for all clients on the secured dementia unit who received narcotic pain medications. The director of nursing also called the police who started an investigation.

The police reviewed over 60 hours of surveillance video, during which they observed the AP remove narcotic pain medications from residents supplies, sign out the medication in the narcotic log and documented in the medication administration record, but failed to give the medication to a resident. On four occasions, video showed the AP put the pills into her mouth under her mask, on three occasions the AP put the pills into her pocket, and on eight occasions, video showed the AP walk out of the medication room with pills in her clenched hand.

During an interview with a police officer, the AP admitted to the officer that she stole the narcotic pain medications from several unnamed residents.

During an interview with MDH surveyors, the AP admitted to taking residents' narcotic medications. The AP told the surveyors that she only took from resident PRN supplies, and alleged that she never denied a resident pain medication. The AP also told the surveyors that it was "so easy".

During an interview, the nurse practitioner said that she expressed her concerns to the director of nursing about the number of narcotic pain medications that the AP signed out, and the possibility that the AP overmedicated residents.

During an interview, the director of nursing said that the AP failed to follow the PRN policy by not assessing residents' pain or trying alternative pain interventions before giving residents narcotic pain medications. The director of nursing said that in the previous year, the AP received counseling for improper destruction of a narcotic, received discipline for improper

medication administration, received training about use of interventions before giving pain medications, and received a suspension for failure to follow medication administration policies. The director of nursing said they reviewed resident progress notes and determined that none of the residents experienced harm due to the theft of the medications.

During interviews, family members said they were unaware that the facility investigated a staff member for stealing narcotic pain medications. One family member expressed concern that the facility inadequately managed their family member's pain, but indicated it improved once hospice became involved.

The AP did not respond to phone messages or e-mail requests for an interview, and did not respond to a subpoena.

In conclusion, financial exploitation occurred.

**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:
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

**Vulnerable Adult interviewed**: No
**Family/Responsible Party interviewed:** Yes, Except Residents 1 and 4
**Alleged Perpetrator interviewed:** No, did not respond to subpoena

**Action taken by facility:**
The facility provided education to all nurses on drug diversion, destruction of narcotics, and medication administration, as well as competency training on controlled medications.
The facility conducted audits of PRN medication administration.

The AP no longer works at the facility.

**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.

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
Lake County Attorney
City of Silver Bay Attorney
Silver Bay Police Department
Minnesota Board of Nursing