# Office of Health Facility Complaints
# Investigative Public Report

**Maltreatment Report #:** HL2130049M
**Compliance #:** HL2130050C

**Date Concluded:** March 17, 2021

**Name, Address, and County of Licensee Investigated:**
Spectrum Community Health Inc.
6205 Crossman Lane
Inver Grove Heights, MN 55076
Dakota County

**Name, Address, and County of Housing with Services location:**
Babbitt Carefree Living
1 Central Boulevard
Babbitt, MN 55706
St. Louis County

**Investigator's Name:** Peggy Boeck, RN
Special Investigator

**Facility Type: Home Care Provider**

**Finding: Substantiated, facility and 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 that the Alleged Perpetrator (AP) neglected the client when the AP destroyed the client's anti-seizure medication. When the client had a seizure that would not stop, the medication was not available.

**Investigative Findings and Conclusion:**
Neglect was substantiated. The AP neglected to provide the client with her rescue anti-seizure medication because the AP destroyed the medication, failed to notify hospice that the facility did not have the medication, and the facility had no system in place to ensure the prescribed rescue anti-seizure medication was stored and available for use. The facility and the alleged perpetrator were responsible for the maltreatment.

Financial exploitation was substantiated. The AP is responsible for the financial exploitation. The AP destroyed the rescue anti-seizure medication that belonged to the client. The facility policy on destruction of medications indicated any medications left at the facility after a client's death, termination of services, or when discontinued must be destroyed by a registered nurse or licensed practical nurse and a witness. The client's rescue anti-seizure medication (midazolam) had a current physician order and had not expired when the AP took the clients medication and destroyed it.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. In addition, hospice personnel including a hospice nurse and the hospice medical director were interviewed. The client's medical records, facility documentation, and facility policies and procedures regarding destruction of medications were reviewed.

The client lived at the facility for several years due to diagnoses that included a history of strokes and a seizure disorder. The client received services from the home care provider that included bathing assistance, meal assistance, dressing assistance, grooming, vital signs, monthly weights, safety checks, repositioning, housekeeping, escorts, transfers, toileting, medication storage, and medication management.

The client's individualized medication management plan indicated the facility stored all the client's medications outside the client's apartment in a locked container stored in a locked medication closet in a secure office. The plan further indicated all controlled substances managed by the facility were secured and accounted for several times weekly.

The client enrolled in hospice and the hospice physician prescribed the client's medications; which were given to the client by facility staff. One of the client's prescribed medications was a controlled substance (midazolam) used as rescue treatment for seizures. The medication was a liquid, stored at room temperature, withdrawn by syringe, and placed into an atomizer (a device that delivered the medication in a fine mist for quick absorption). The atomizer was then sprayed into the client's nose (intranasal administration) during a seizure to stop the seizure. The facility kept the midazolam locked up with other controlled substances the facility managed, per their policy. The facility received two vials of the midazolam the day after the client enrolled in hospice.

One morning, a staff member notified the facility nurse that the client was not acting herself, staring off to the side, not responding to her name, and had foot tremors. The facility nurse assessed the client and notified the hospice nurse that she thought the client was having a stroke. The hospice nurse arrived, observed the client having a continuous seizure, and asked the facility nurse for the rescue anti-seizure medication (midazolam). The facility nurse went to the nurse's office, into the locked closet, and opened the locked container. The nurse

discovered a document that showed that the midazolam had been destroyed by the AP six weeks earlier.

The hospice nurse contacted the hospice physician, who gave other orders for a medication that the facility had available for use for the client. The hospice nurse tried the medication, but the seizures did not stop. The hospice nurse called the physician again and got another order to use a different medication. The hospice nurse tried the next medication, but the client's seizures continued. The hospice nurse called the physician again and the physician ordered the client sent to the hospital by ambulance. The client had been seizing for more than two hours when she was transferred to the hospital.

The client arrived at the hospital, where they gave the client midazolam intravenously twice and the seizures stopped. The client passed away four days later due to the seizures.

During interview the hospice nurse stated their nurse would verify that the medication list matched with the facility medication administration record (MAR) each time they visited the client. Each visit noted the midazolam as an active order and available for use on the client's MAR. The hospice nurse stated the AP did not notify hospice that she destroyed the midazolam, so they thought it was still available to use.

During interview a facility nurse stated the midazolam was on the client's medication administration record. The nurse stated the AP told her she destroyed the clients midazolam.

During interview a hospice physician stated there were significant delays in supplying treatment to the client on the day of the incident. The physician stated the client would likely have stopped seizing if the facility had supplied the midazolam, but since they did not have it anymore, the client seizure lasted several hours. The physician stated intranasal midazolam would get into the client's system quickly and that was a standard seizure treatment. The physician stated if the facility had told them that they did not want the midazolam in the facility, hospice would have ordered another rescue anti-seizure medication or formulation to have on hand if the client had a seizure.

During interview the AP stated she thought she did the right thing for the facility by destroying the client's midazolam. The AP stated the facility did not like to have controlled medications in liquid form because of the risk of diversion (when an employee steals medication for personal use). The AP stated she should have notified hospice before she destroyed the client's midazolam so they could order something else. The AP stated she understood all the client's medication belonged to the client.

In conclusion, neglect and financial exploitation were 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.

**Neglect: Minnesota Statutes, section 626.5572, subdivision 17**
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

**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.

**Vulnerable Adult interviewed**: No, deceased.
**Family/Responsible Party interviewed**: Yes
**Alleged Perpetrator interviewed**: Yes

**Action taken by facility:**

No action taken.

**Action taken by the Minnesota Department of Health:**

The facility was found to be in 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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
St Louis County Attorney
Babbitt 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 |
|---|---|---|---|
| | H21030 | A. BUILDING: _____ B. WING _____ | C 03/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SPECTRUM COMMUNITY HEALTH INC | 6205 CROSSMAN LANE INVER GROVE HEIGHTS, MN 55076 |

| (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 |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>HOME CARE PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey.<br><br>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br><br>On March 4, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL21030050C/#HL21030049M. At the time of the survey, there were #29 clients receiving services under the comprehensive license.<br><br>The following correction orders are issued for #HL21030050C/#HL21030049M, tag identification #0325 and #0900. | 0 000 | The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction."<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b). | |
| 0 325 | 144A.44, Subd. 1(a)(14) Free From Maltreatment<br><br>Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or | 0 325 | | |

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| 0 325 | Continued From page 1<br><br>in an assisted living facility licensed under chapter 144G has these rights:<br>(14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interviews, and document review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 was neglected and financially exploited.<br><br>Findings include:<br><br>On March 4, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect/financial exploitation occurred, and that the facility and an individual staff person were responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred. | 0 325 | No Plan of Correction (PoC) required. Please refer to the public maltreatment report for details. | |
| 0 900 SS=G | 144A.4792, Subd. 1 Medication Management; Comprehensive<br><br>Subdivision 1.Medication management services; comprehensive home care license. (a) This subdivision applies only to home care providers with a comprehensive home care license that provide medication management services to clients. Medication management services may not be provided by a home care provider who has a basic home care license. | 0 900 | | |

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| 0 900 | Continued From page 2<br><br>(b) A comprehensive home care provider who provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines.<br><br>(c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and client and client representative, if any; disposing of unused medications; and educating clients and client representatives about medications. When controlled substances are being managed, stored, and secured by the comprehensive home care provider, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 22.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to implement medication and controlled substance policies when they destroyed a medication belonging to one of one client (C1) reviewed for medication errors. Harm occurred to C1 when C1 had a seizure, the | 0 900 | | |

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| 0 900 | Continued From page 3<br><br>hospice nurse requested the prescribed medication, but a facility nurse had destroyed the medication six weeks earlier. C1 continuously seized for over two hours until she received treatment at a hospital.<br><br>This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>Findings include:<br><br>C1 admitted to the facility on June 21, 2017 due to diagnoses that included stroke with left side weakness and epilepsy. C1's service plan dated November 9, 2020 indicated C1 received the following services from the home care provider: activities, bathing assistance, behavior support, meals, dressing assistance, grooming assistance, appointment assistance, vital sign monitoring, safety checks, hourly repositioning, cleaning, laundry, escorts, toileting, wound care, medication storage, and medication management.<br><br>C1's hospice notes dated September 22, 2020, September 29, 2020, October 13, 2020, October 27, 2020, November 10, 2020, November 24, 2020, December 8, 2020, December 22, 2020 , January 5, 2021, January 19, 2021, and February 2, 2021, indicated C1 had an order for midazolam (a rescue anti-seizure medication given to stop prolonged seizures) 10 milligrams (mg)/2 milliliters (ml) 0.5 ml to each nostril via nasal | 0 900 | | |

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| 0 900 | Continued From page 4<br><br>atomizer as needed for prolonged seizure (convulsions that last more than five minutes), ok to repeat once in 15 minutes if seizure persists.<br><br>C1's physician order signed December 8, 2020 by hospice medical director (MD)-D indicated midazolam 10 mg/2 ml solution- as needed, give 0.5 ml to each nostril via atomizer as needed for prolonged seizure or convulsions lasting longer than five minutes, OK to repeat once in 15 minutes if seizure persists. The form indicated the physician signature validated the order for one year.<br><br>C1's progress notes dated September 21, 2020 through February 11, 2021 were reviewed. No documentation in C1's progress notes indicated that midazolam was discontinued, expired, or destroyed.<br><br>C1's December 2020, January 2021, and February 2021 medication administration records (MARs) indicated midazolam 10 mg/2 ml, give 0.5 ml to each nostril via atomizer as needed for prolonged seizures or convulsions lasting longer than 5 minutes. OK to repeat once in 15 minutes if seizure persists.<br><br>C1's hospital record dated February 2, 2021 at 5:26 p.m. indicated C1 "continuously seizing over the last three hours". Client temperature was 102 degrees Fahrenheit (F) (normal average temperature 97 degrees F to 99 degrees F) and pulse was 170 beats per minute (bpm) (normal 60 bpm to 100 bpm). The client was described as actively seizing, with "rhythmic movements flexion of left upper extremity and left lower extremity." The client was given given midazolam intravenously twice and the seizure stopped. | 0 900 | | |

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| 0 900 | Continued From page 5<br><br>During interview on March 11, 2021 at 12:08 p.m. hospice registered nurse (RN)-A stated the facility never told hospice they could not provide C1's midazolam or that it had been destroyed. RN-A stated hospice had prescribed midazolam for other clients at this facility before C1. RN-A stated the facility did not contact hospice for an alternative rescue medication for C1's seizures, and midazolam was listed on C1's MAR.<br><br>During interview on March 11, 2021 at 2:53 p.m., hospice medical director (MD)-D stated C1's midazolam likely would have stopped C1's seizure if it would have been administered at the facility as prescribed. MD-D stated the facility never notified hospice that they destroyed C1's midazolam, and if they had, he would have ordered another rescue anti-seizure medication or formulation for C1 for the facility to have on hand.<br><br>During an interview on March 12, 2021 at 8:46 a.m. vice president of operations (VPO)-E stated she did not participate in any discussion regarding destruction of C1's midazolam. VPO-E stated she believed registered nurse (RN)-F and registered nurse/executive director (RN/ED)-H made the decision independently to destroy C1's midazolam. VPO-E stated RN/ED-H ultimately held responsibility for the decision to destroy C1's midazolam as RN-F's supervisor. VPO-E verified the midazolam belonged to C1, but no one contacted C1's representative or hospice to inform them of the destruction.<br><br>During interview on March 12, 2021 at 1:28 p.m., RN-F stated she counted narcotics with RN/ED-H on an unknown date prior to C1's seizure. RN-F could not locate C1's midazolam and RN/ED-H stated she had destroyed it. RN-F stated she did | 0 900 | | |

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| 0 900 | Continued From page 6<br><br>not assist RN/ED-H with destroying C1's midazolam. RN-F stated she thought the policy required two nurses to destroy a narcotic.<br><br>During an interview on March 12, 2021 at 2:50 p.m. administrative assistant (AA)-G stated she watched RN/ED-H destroy C1's medication on December 21, 2020 and signed as witness to the destruction. AA-G stated RN/ED-H opened the vials of C1's medication and poured them into the RX destroyer (a chemical drug destruction solution). AA-G stated she did not know what the medication was prescribed for and she had no medication training.<br><br>During interview on March 12, 2021 at 3:15 p.m. RN/ED-H stated the facility stored C1's midazolam in the nurse's office and verified its presence twice weekly. RN/ED-H stated she made the decision to destroy C1's midazolam on December 21, 2020. RN/ED-H stated C1's midazolam did not expire or have an order to discontinue. RN/ED-H stated she thought she spoke with RN-A about destroying C1's midazolam but did not document the conversation. RN/ED-H stated she knew the midazolam belonged to C1 but did not contact anyone when she decided to destroy the medication. RN/ED-H stated she was new in her role at the facility and thought destroying C1's midazolam would protect the facility from possible drug diversion as it was a liquid controlled substance.<br><br>The facility Record of the Inventory and Destruction of Controlled and Uncontrolled Substances document dated December 21, 2020 signed by RN/ED-H and AA-G, indicated "we, the undersigned verify that we have inventoried the following substances which are excess, obsolete, | 0 900 | | |

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| 0 900 | Continued From page 7<br><br>or discontinued, and they have been destroyed in our presence". Listed was C1's midazolam, 2 vials of 10 mg/2 ml.<br><br>The facility Disposition or Disposal of Medication policy dated October 1, 2018 indicated any medications managed and secured by the facility that are left after a client death, termination of client services, or the medication is permanently discontinued, must be destroyed by the RN or licensed practical nurse (LPN) and witnessed by one other person. The policy further indicated unused portions of a controlled substance may be given to the client or client's representative upon termination of client services under certain conditions.<br><br>The Controlled Substance policy dated March 20, 2019 indicated the facility would "take every step possible to avoid handling or administering liquid narcotics. We will notify our hospice providers and pharmacies that we need these medications dispensed in an alternative form such as suppositories or melt-away tabs". The policy further indicated that unused portions of any controlled substance after a client's death, discharge, or if the controlled substance was discontinued must be disposed of by the licensed nurse and a witness.<br><br>The facility provided no additional documentation.<br><br>TIME PERIOD FOR CORRECTION: SEVEN (7) DAYS | 0 900 | | |