

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H00802687M

Date Concluded: July 30, 2024

Compliance #: H00807404C

Name, Address, and County of Licensee

Investigated:

M Health Fairview
2450 Riverside Avenue
Minneapolis, MN 55454
Hennepin County

Facility Type: Hospital

Evaluator's Name: Lissa Lin, RN
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 (AP) abused two patients (patient 1 and patient 2) when he told other staff members he planned to overmedicate his patients.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was inconclusive. The AP failed to follow provider medication administration instructions when giving certain psychotropic and anxiety medications to patient 1 and patient 2. However, there was conflicting evidence the AP's error was intended to chemically restrain the patients. Neither patient suffered harm. Interviews and records reviewed provided conflicting information regarding the AP's comments to staff about his plan to overmedicate patients. In addition, the hospital failed to provide requested records and video related to the allegation.

The investigator conducted interviews with nursing staff and the AP. The investigation included review of hospital records, pharmacy records, the facility's internal investigation, staff schedules, training records and related facility policy and procedures.

The investigator requested investigation records and contact information for several staff members, including the AP. The hospital had approximately two weeks to provide the information but requested an additional two-week extension to provide the requested records. Compliance documentation indicated there were flowsheets, video and at least one text message reviewed by management during their internal investigation of the AP. The hospital did not provide flowsheets, video, or a copy of the text message despite a subpoena request for all investigation records, including any video.

Patient 1

Patient 1 admitted to the hospital through the emergency department (ED) for substance abuse and disorganized thinking. A nurse assessed patient 1 as manic, paranoid, tense, and irritable. The nurse practitioner placed him on a 1:1 observation with assault precautions and no roommate. Staff performing the 1:1 needed to stay with him at all times, even when he slept.

The internal investigation indicated during rounds the AP entered patient 1's room and observed white substance on his face and on the bed. The AP said he assumed patient 1 had spit out the Ativan (antianxiety) pill given earlier by another nurse for agitation. The AP said he recalled the night nurse charted she gave patient 1 haloperidol (antipsychotic), Ativan and Benadryl (combined, they are called a B52 and given for acute agitation) but he spit out some of the pills. The AP documented he found a small white pill on the floor in patient 1's room. He did not check with the pharmacy of another nurse if the pill was Ativan. He disposed of it and readministered a new Ativan tablet. The AP also administered Zyprexa, an antipsychotic medication also used for general anxiety.

Several hours later, the AP observed patient 1 "slithering" on the hallway floor, acting "animated, agitated and hyper verbal." Patient 1 spent the remainder of the day in his room, still on 1:1 observation. He later came out and participated in the community.

The internal investigation indicated the night nurse reported she verified administration of the Ativan by checking the patient for cheeking. Management had a concern the AP committed fraud when he changed the night nurse's documentation in the medical administration record (MAR) after he found the white pill in patient 1's room. He changed the status from "given" to "not given" in the comments section because he assumed he found the Ativan pill administered during the night shift.

The patient's medical record indicated the AP administered PRN (as needed) haloperidol, Benadryl and Ativan, a PRN Zyprexa and a PRN hydroxyzine, "all with good effect" and collected vital signs on patient 1.

Patient 1's provider orders instructed Zyprexa administration first for agitation unless otherwise specified, three times daily prn. Doses should be at least 2 hours apart. The provider orders instructed Ativan administration three times daily and every 4 hours prn. The AP administered both Ativan and Zyprexa together.

Patient 2

Patient 2 admitted to the hospital through the emergency department (ED) on a 72-hour hold for suicidal ideation, agitation and psychosis. He had been in-patient for a few weeks and received scheduled and prn antipsychotic and anti-anxiety medications.

The AP's personnel file included records related to an incident with patient 2. During the day shift, the AP documented patient 2 was anxious and preoccupied with auditory hallucinations and became agitated when pressed about the hallucinations. The AP stated patient 2's mother requested adding Thorazine (mood stabilizer) to his daily medications.

Patient 2's medical record indicated the AP administered PRN Thorazine for the hallucinations and PRN Ativan and hydroxyzine for increasing anxiety. He recorded patient 2's vital signs. Patient 2 ate breakfast, then went to his room to sleep since he had not slept well the night before.

Patient 2's provider orders instructed hydroxyzine administration only if there was no other oral PRN medication for anxiety. The AP administered Ativan and hydroxyzine together.

Review of internal investigation records indicated the AP told management he used his nursing judgement when he gave patient 1 prescribed and PRN medications together. The AP said he felt success when patient 1 was able to sleep, and patient 2 "behaved" during the shift. The internal investigation included asking if the AP made comments such as, "you guys, I'm intentionally overmedicating my patients today" and "I'm going to focus on knocking these people (patients) out." The AP denied making such comments. The internal investigation failed to indicate from whom or where those alleged comments derived from.

The AP's personnel file record indicated the AP failed to follow provider orders, monitor patient 1 and patient 2's respiratory status and collect vital signs for one hour after each dose of Ativan.

During an interview, the nurse practitioner said providers were not typically notified when staff gave oral PRN medications, only if intramuscular PRN medications were given, because those were considered restraints. She said sometimes numerous medications were needed to treat agitation and psychosis in people who were resistant. The nurse practitioner said she did not recall any concerns with the AP or how he administered medications. Record review indicated several months earlier she spoke to the AP about patient 2's Ativan medication and said he did not need Ativan, had other scheduled medications to keep him calm. The nurse practitioner did not contact management about any concerns she had regarding the AP until after his employment ended.

During an interview with a nurse manager, she said the AP should have contacted the pharmacy or checked an online pill identifier when he found the white pill in patient 1's room. He should have verified what it was before he gave another dose of Ativan. The AP did not follow policy and destroy the found pill with another nurse present.

During an interview, another nurse manager said while the AP did not administer the least restrictive doses of medication and assess the patients, neither patient 1 nor patient 2 were in danger or maltreated.

One nurse failed to participate in a scheduled phone interview. Other nursing staff failed to respond to phone and email requests for interviews.

During an interview, the AP said he never talked about overmedicating his patients, not even as a joke. He said the PRN medications had parameters that gave nurses some leeway on when to give them. The AP had training on medication administration, and contacted the nurse practitioner when he had questions about giving medications. The AP said regarding patient 1, he recalled the day being weird and difficult due to a heavy patient load. Patient 1 was an aggressive new admission, who cornered him and threatened to kill him when the AP offered to help him dress. The AP said he recalled telling a co-worker that the "B52" worked for patient 1 and he would give it again. The AP said he had good rapport with patient 2. However, that day patient 2 paced the halls, kept asking for medication, and told the AP he was "ramping up and needed meds." The AP gave patient 2 a PRN medication and he was still able to participate in the community. The AP said he had given patient 2 multiple PRN medications before with no problems and the nurse practitioner was aware of that. The AP said he was shocked when management sent him home under investigation. Three days later, management told him he overmedicated patient 1 and patient 2. The AP said he had no idea he had done anything wrong. The AP said perhaps he should have given fewer PRN medications, but no one was harmed. The AP said he offered to attend medication retraining but management said he was no longer employed there.

The investigator did not contact patient 1 due to cognition issues. The investigator called patient 1's family member for an interview, but she declined.

The investigator called patient 2 for an interview, but the person who answered said he was not patient 2 and ended the call. The investigator contacted patient 2's family member for an interview, but she declined.

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

Abuse: Minnesota Statutes section 626.5572, subdivision 2.

"Abuse" means:

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and

(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

Vulnerable Adult interviewed: Patient 1 not contacted due to cognition. Attempted to contact patient 2.

Family/Responsible Party interviewed: Family of patient 1 and patient 2 declined.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility conducted an internal investigation. The AP is no longer working 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 Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00200	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER M HEALTH FAIRVIEW UNIVERSITY OF MN	STREET ADDRESS, CITY, STATE, ZIP CODE 2450 RIVERSIDE AVENUE MINNEAPOLIS, MN 55454
---	---

(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
6 000	<p>INITIAL COMMENTS</p> <p>The Minnesota Department of Health investigated an allegation of maltreatment, complaint H00802687M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.</p>	6 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____