Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: H1559001M **Date Concluded:** May 4, 2021

Name, Address, and County of Licensee Investigated:
Lakewood Health System Hospice
401 Prairie Avenue NE
Staples, MN 56479
Wadena County

Facility Type: Hospice

Investigator's Name: Angela Vatalaro, 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 (drug diversion) a deceased patient when she falsified a witness signature of destruction of his controlled medications.

Investigative Findings and Conclusion:
Financial exploitation (drug diversion) was substantiated. The AP was responsible for the maltreatment. The AP ordered and received the patient's morphine (opioid medication to treat moderate to severe pain,) lorazepam (antianxiety agent,) and haloperidol (antipsychotic medication.) The facility did not have delivery record of the patient's morphine or record of the destruction. The facility requested the pharmacy send delivery records and verified the AP signed receipt all three of the patient's medications. The AP indicated she destroyed the patient's lorazepam and haloperidol; however, the witness signature used was inauthentic.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and the patient's family. The AP agreed to answer questions in written format. The investigation included contact with law enforcement and review of the law enforcement

report. The investigation included a review of patient's medical records, hospital discharge records, hospice admission records, narcotic medication orders, pharmacy delivery records, narcotic destruction records, the AP's personnel file, and facility policies related to controlled medications.

The patient's terminal diagnosis included Alzheimer's disease. The patient's hospice plan of care included end of life care coordination, pain control, case management, music therapy, and spiritual care.

One morning, the patient discharged from the hospital with an order for hospice home-care services, and a prescription for morphine. The hospital sent the prescription to the local pharmacy to fill. The patient's family picked up the morphine to use in the home. The AP (a registered nurse) received the hospice referral and ordered the patient morphine, lorazepam, and haloperidol off hospice standing orders.

The next day the AP signed the pharmacy delivery receipt record for the morphine, lorazepam, and haloperidol at 2:00 p.m. That same day the patient admitted to hospice services by another hospice-admitting nurse. The hospice-admitting nurse reconciled the patient's home medications, which included morphine picked up by family on hospital discharge at 2:21 p.m. The admitting nurse did not bring the medications with her to the patient's home evidenced by admission documentation time stamped at 2:21 p.m., referenced against drug delivery records time stamped at 2:00 p.m. During the patient's hospice admission, family declined the morphine, lorazepam, and haloperidol, due to having a bottle of morphine supply already on hand. The admitting nurse relayed this information to the AP. The AP told the admitting nurse she would keep the medications in the medication cart just in case the patient needed the medications.

The next day the patient passed away. The admitting nurse conducted a death visit and destroyed the morphine the patient had at his home (provided by family) evidenced by documentation on a drug disposal form and a witness signature.

A review of the facility's internal investigation indicated the director of home-based services (DHBS) and the assistant director of nursing (ADON) performed an audit in the medication room and medication cart. They did not observe the patient's medications (morphine, lorazepam and haloperidol) in the medication cart prior to the AP's documented medication destruction. The admitting nurse denied seeing the patient's medications in the medication cart. In addition, another nurse who frequently accessed medications from the medication cart denied seeing the patient's medications.

The AP's personnel file included documentation the AP did not follow protocol when she disposed of the deceased patient's medications. The AP's leader asked her to wait on medication destruction and she did not want to wait. Since the AP did not want to wait, she received instruction to ask one of the nurses to assist her with disposal protocol. Instead, the

AP asked another nurse to open the medication room and she went into the medication room alone. The same document indicated the AP falsified the witness signature on the drug disposal form. In addition, the AP went to a different patient's home twice unauthorized with her rational as, once for a visit and a short time later because she forgot her phone. The AP did not document this visit. The AP went to another patient's home unauthorized, and the visit was undocumented. The same documentation indicated the AP lied to her director for reasons of leaving work when she went on the mentioned visits.

During an interview, the ADON stated that AP was aware of proper controlled medication disposal, which included a witness and filling out a drug disposal form. The ADON stated one morning the AP came to her office and said she needed to destroy medications. She said it was odd that the AP had an urgent need to destroy medications that morning. She stated the AP returned from destroying medications and the AP said she did not have a witness and did not fill out the drug disposal form. The ADON instructed her to fill out the medication disposal form per protocol. The ADON stated it was also odd that she had to revisit expectations of medication disposal with the AP. She expected to see just the AP's signature on the patient's drug disposal form however; it included another nurse's witness signature. She provided this information to DHBS.

During an interview, the DHBS stated while in the midst of investigating the AP's involvement of unauthorized visits to a patient's home and discrepancies with narcotic inventory she discovered this additional discrepancy with the patient's morphine, lorazepam, and haloperidol. The DHBS stated because of the distance from the facility to the patient's home, the admitting nurse could not have been present at the time the AP received the medications from the pharmacy. The DHBS stated the AP did not log delivery of the morphine within the hospice records. The DHBS stated during her investigation she discovered a nurse opened the door to the medication room for the AP, however, a nurse did not witness the AP destroy controlled medications which was protocol. She later checked the AP's documentation, which indicated the AP's signature and the nurse who let the AP into the medication room as witness. The DHBS reviewed the nurse witness signature that indicated medication destruction with the AP and it did not appear to be authentic. The facility pulled signature samples to compare, and the witness signature was not authentic. She provided the signature samples to law enforcement. She said law enforcement interviewed the witness who denied the signature and denied witnessing the AP destroy narcotics. She said the AP is no longer employed by the facility and there is an open criminal case involving the AP with law enforcement.

During an interview, a nurse stated she worked at the care center and not for hospice. She said hospice medications stored in the care center locked medication room. She said she opened the medication room door for the AP and did not recall the reason the AP wanted to enter. She said the AP asked her the process of medication destruction. She informed the AP of the process and was in the medication room with the AP, however; she did not witness the AP destroy narcotics and the witness signature identified on the patient's drug disposal form that

indicated her signature was not hers. She said she did not recall if she left the medication room with the AP.

During an interview, the patient's family stated the hospice-admitting nurse offered the patient morphine, lorazepam, and haloperidol. The family declined the additional medications as they had already picked up the patient's morphine ordered on hospital discharge. The patient's family said when the patient passed away the hospice-admitting nurse destroyed the patient's morphine in the home with a family member present as witness.

During an interview, the hospice-admitting nurse stated the AP ordered the patient morphine, lorazepam, and haloperidol. She said she relayed to the AP that the patient did not need the medications ordered. The AP stated she had already ordered the medications and would store them in the medication cart.

A review of the AP's written responses to interview questions indicated the AP ordered and received the patient's morphine, lorazepam, and haloperidol. She stated she kept a copy of all three of the medication delivery records, and placed into a binder for facility records. She stated she did not know why the facility did not have a copy of the morphine delivery. She added she did not recall her conversation with the hospice-admitting nurse. She stated the day the patient's lorazepam and haloperidol destroyed, she asked for clarification on proper disposal of medications from DHBS and ADON as this was new to her job duties. She stated it was the first time she needed to destroy hospice medications in the care center. The ADON told her to have one of the care center nurses assist her with medication destruction. The AP stated a care center nurse let into the medication room and witnessed destruction. She stated the care center nurse watched her put the patient's lorazepam and haloperidol into the destruction box and they left the medication room together. The AP stated the ADON did not inform her the witness signature needed signing by the witness herself. She stated she wrote the witness signature down to indicate who witnessed the medication destruction. The AP stated she did not document destruction of the patient's morphine because she did not destroy it. The AP also stated she did not take the patient's medications out of the building.

A review of the law enforcement report indicated law enforcement interviewed the care center nurse who let the AP into the medication room. The care center nurse denied witness of medication destruction while in the medication room with the AP and denied the witness signature was hers. The medication destruction bin jammed the day after the AP documented the patient's lorazepam and haloperidol destruction. The bin opened by a nurse and she observed the patient's lorazepam blister pack. The lorazepam pills observed to be intact in the blister pack. In the medication room garbage, the facility found cleaned syringes and packages of saline solution syringes. The saline solution based on the packages amounted to 30 ML. One of the nurses observed the patient's haloperidol prescription bottle had a liquid substance observed in it and the bottle was in the destruction bin.

In conclusion, financial exploitation (drug diversion) was substantiated.

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. The patient was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes, provided a written response to interview questions.

Action taken by facility:
The facility conducted an internal investigation and contacted law enforcement. The AP was no longer employed at the facility.

Action taken by the Minnesota Department of Health:

No further action taken at this time.

cc:
Health Regulation Division – Licensing and Certification
The Office of Ombudsman for Long-Term Care
Wadena County Attorney
Staples City Attorney
Staples Police Department
The Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03591	A. BUILDING: _____ B. WING _____	C 05/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD HEALTH SYSTEM HOSPICE	401 EAST PRAIRIE AVENUE STAPLES, MN 56479

(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
4 000	Initial Comments The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H1559001M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for #H1559001M, tag identification 1465. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	4 000		
41465	144A.751 Subdivision 1 (14) HOSPICE BILL OF RIGHTS (14) be treated with courtesy and respect and to have the patient's property treated with respect; This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one patients reviewed (P1) was free from maltreatment. P1 was financially exploited.	41465	No plan of correction is required for tag 1465. Please refer to the public maltreatment report for details.	

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41465	Continued From page 1 Findings include: On May 4, 2021, the Minnesota Department of Health (MDH) issued a determination that financial exploitation occurred, and that the an individual staff person was 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.	41465		