Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H16064247M, H16064283M
Compliance #: H16066512C

Date Concluded: June 29, 2023

Name, Address, and County of Licensee Investigated:
ST. Croix Hospice
1001 South Pokegama STE D
Grand Rapids, MN 55744
Itasca County

Facility Type: Hospice

Evaluator's Name: Carol Moroney 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 patients when she diverted controlled substance medications.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP diverted 24 patients' controlled substance medications.

The investigator conducted interviews with facility staff members, physician staff, and pharmacy staff. The investigator reviewed facility records, the facility internal investigation and pharmacy records. The investigator also interviewed law enforcement. The AP declined to be interviewed.

The patients received hospice services and lived in their own homes. The patients' required a hospice registered nurse (RN) visit their homes to provide assessments, medication monitoring, pain assessments and overall medical care. The RN responsibility included contacting the patients' provider for any needed pain medications.

The hospice agency's process for requesting and transcribing medication orders included the RN contacting the provider and discussing medication needs over the phone. The nurse then updates the electronic medication administration record (eMAR) with the verbal order which then syncs to the e-prescribing system. When the provider completes the prescription through the e-prescribing system, it automatically submits the prescription to the agency's primary pharmacy. The primary pharmacy fills prescriptions and mails them directly to the patient's home. If the medication requires a fill at a local pharmacy, the pharmacy delivers the medication to the patient's home. The agency process does allow in emergent situations (urgent medication not available at the primary pharmacy, new admission, etc.) for the RN to manually enter the prescription into the e-prescribing software but is required to also enter the prescription manually into the eMAR.

The agency investigation indicated the AP stated she fraudulently acquired oxycodone (a narcotic pain medication) and other controlled substances by deceiving the provider into issuing prescriptions for patients when they did not clinically require the controlled substance. The AP contacted the provider and provided false clinical information about the patients. The AP then manually entered the prescription order into the e-prescribing software but did not update the eMAR in the facility's electronic health records to avoid the new medication order from being known to others. In doing so, the AP bypassed the safety systems of checking the medication transcription into the eMAR. After the AP contacted the provider and received the medication order, the AP took the prescription order to a local pharmacy (not the hospice agency pharmacy) to have the medications filled and provided into her custody. The AP used the same method of diversion for all 24 patients.

Review of the patients' medical records and MARs indicated the patients did not have a clinical need for the medications the AP had requested to be ordered.

The agency investigation determined the AP likely diverted over 13,400 doses of 20 milligram (mg) oxycodone, 930 doses of 5 mg oxycodone, almost 4,900 doses of 10 mg oxycodone, 240 doses of 30 mg oxycodone, 30 doses of extended release 60 mg oxycodone, 230 doses of hydromorphone (narcotic pain medication), 51 fentanyl patches, and 30 doses of tramadol (controlled pain medication). This totaled 19,811 diverted controlled medications between the 24 patients. The patients had no knowledge the AP used their names to divert the medications.

The agency investigation indicated the pharmacy provided a list to the agency of patients who had numerous prescriptions for oxycodone that were filled and picked up by the AP. Two of the patients had recently died and the agency staff who went to the home of the death, found no oxycodone at either house.

During an interview, the provider stated when a nurse called and requested pain medication and if the symptoms reported to the provider were consistent with the request, the provider would prescribe the requested medications.

During an interview, the pharmacist stated their pharmacy identified the concern of missing medications. The pharmacist noticed the same nurse (the AP) requested excessive amounts of pain medications for a variety of different patients, in a very short period. The pharmacist reported it. The pharmacist said they always monitor for excessive pain prescriptions filled by the same nurse.

The law enforcement report indicated the AP was pulled over by police for driving recklessly. When pulled over, law enforcement found the patient's medications. When asked, the AP said she was a hospice nurse and was delivering medications to the patients. The AP said she was under investigation by her employer for stealing medications. The police officer searched the AP's car and found empty medication packaging, pill bottles and a small lockbox with the label "Property of [Agency]" on it.

During an interview, law enforcement stated the AP said she had stolen the narcotics to sell them.

The AP declined an interview with the investigator.

The agency addressed the diversion of patients' medication billing, and the patients were not impacted financially. Due to the nature of diversion, interviews with the patients were not conducted.

The agency completed re-education with all the nurses about the proper procedure for medication management. The agency completed education with clinical leadership to ensure medications are reconciled properly. The agency provided education to the provider involved. The agency also completed a full implementation of a new e-prescriber dose spot eliminating risk associated with previous vendor. The AP is no longer employed by the agency.

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;

(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or

Vulnerable Adult interviewed: No. See report.
Family/Responsible Party interviewed: No. See report.
Alleged Perpetrator interviewed: Attempted, but the AP declined an interview.

Action taken by facility:
The agency conducted an internal investigation into the diversion. The agency completed re-education with all of the nurses about the proper procedure for medication management. The agency completed education with clinical leadership to ensure medications are reconciled properly. The agency provided education to the provider involved. The agency also completed a full implementation of a new e-prescriber dose spot eliminating risk associated with previous vendor. The AP is no longer employed by the agency.

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
The Office of Ombudsman for Mental Health and Developmental Disabilities
Itasca County Attorney
Grand Rapids City Attorney
Grand Rapids Department
Minnesota Board of Nursing
Drug Enforcement Administration

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 241606	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/23/2023

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 The Minnesota Department of Health documents the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN, WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H16064283M and #H16064247M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.	40000		
40395	HANDLING OF PATIENTS' FINANCES AND PROPERTY CFR(s): 4664.0040 Subp. 2 Handling patient finances. A licensee may assist hospice patients with household budgeting, including paying bills and purchasing household goods, but must not otherwise manage a hospice patient's finances. A licensee must provide a hospice patient with receipts for all transactions and purchases paid with the hospice patient's funds. When receipts are not available, the transaction or purchase must be documented. A licensee must maintain records of all such transactions.	40395		

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

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40395	Continued from page 1 This LICENSURE REQUIREMENT is NOT MET as evidenced by: The facility failed to ensure 24 of 24 patients reviewed (P1 through P24) were free from maltreatment. The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. Maltreatment Report sent separately.	40395		