OAH 5-0900-37572

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HEALTH

In the Matter of the Correction Orders Issued to Spectrum Community Health, Inc. of the Maltreatment Determination and Correction Orders	**FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION**

This matter came before Administrative Law Judge Jim Mortenson for an evidentiary hearing on September 8, 2021.

Kaitrin C. Vohs, Assistant Attorney General, appeared on behalf of the Minnesota Department of Health (Department). Natalie Zeleznikar, Chief Operating Office of Spectrum Community Health (Spectrum), appeared for Spectrum. Spectrum was not represented by legal counsel. The hearing record closed September 8, 2021, at the conclusion of the hearing.

The Department presented two witnesses: Peggy L. Boeck, RN; and Jessica Sellner, supervisor for the Department's Office of Health Facility Complaints. Spectrum presented one witness, Zeleznikar. The Judge received 25 exhibits from the Department and 12 exhibits from Spectrum into evidence.

STATEMENT OF THE ISSUES

1. Did Spectrum violate Minn. Stat. § 144A.4792, subd. 1 (2020), because it failed to implement its medication management policies when the executive director of a Spectrum care facility destroyed one of M.A.'s medications without informing M.A. or her hospice medical team?

2. Is Spectrum responsible for maltreatment of a client, M.A., by neglect as a result of the failure to provide the prescribed medication which was destroyed?

3. If the answer to either question above is "yes," were the corresponding fines of $3,000 and $5,000, respectively, appropriate pursuant to Minn. Stat. § 144A.474, subd. 11 (2020)?

SUMMARY OF RECOMMENDATION

Spectrum failed to comply with its medication management policy when the executive director of its Babbitt Carefree Living facility (Facility) destroyed one of M.A.s medications without first discussing with M.A. or M.A.'s hospice team. This failure

contributed to the unnecessary suffering of M.A., who required the medication when experiencing a seizure. Thus, Spectrum neglected M.A. and is responsible for maltreatment. The level three fine of $3,000 for the failure to implement the Facility's medication management policy is appropriate. But, because the evidence does not establish that the maltreatment resulted in death, the $5000 fine for the second violation should be reduced to $1,000.

Based upon the evidence in the hearing record, the Administrative Law Judge makes the following:

FINDINGS OF FACT

1. Spectrum is a home care provider with a comprehensive license.[1]

2. Spectrum operates Babbitt Carefree Living, a home care facility in Babbitt, Minnesota.[2]

3. Spectrum provides medication management services to residents at the Facility.[3]

4. Spectrum has a written medication management policy and procedures (Document No. 05-001.13).[4] The policy and procedures address the review of the client's medication record as follows:

> The RN [registered nurse] or LPN [licensed practical nurse] will review each client's medication record when the nurse is setting up medications and at other appropriate times based on the client's need and the client's medication management services including during the client monitoring visit to verify that:
>
> a. Staff is administering the medication as prescribed and is documenting the administration appropriately with authentication by each staff person by discipline or title.
> b. To review and evaluate the administration of PRN [as needed] medications.
> c. To observe signs of medication diversion *and*
> d. To evaluate the effectiveness of the medications and identify any drug-to-drug interaction and untoward or reported side effects.
>
> Any issues or concerns will require follow up and documentation by the nurse, including communications with the prescriber and pharmacy,

[1] Exhibit (Ex.) 15 at 0453.
[2] Ex. 7; Ex. 15.
[3] Ex. 20.
[4] *Id.* This policy was effective May 29, 2019.

education of the client and/or the client's representative, and additional training for staff or other appropriate actions.[5]

5. Velena Bascue was born in 1992. She became an LPN in May 2016 and a RN in January 2019.[6]

6. Spectrum hired Bascue to be the Facility's executive director. She began her employment at the Facility on August 3, 2020.[7]

7. Bascue was trained in her role as executive director by various Spectrum staff while on the job. Her training included instruction on the company's policies and procedures.[8]

8. M.A. was a resident of the Facility since June 21, 2017.[9] M.A. was born in 1935.[10]

9. M.A. had a host of maladies which required medical care. One of the conditions afflicting her was a seizure disorder.[11]

10. M.A.'s service plan with the Facility included medication management.[12] As of June 2020, M.A.'s medications were stored in a locked medication closet in a secure office.[13]

11. Due to M.A.'s failing health, she entered hospice care on September 21, 2020.[14] To aid her when having a seizure (which was not common), her physician prescribed midazolam (Versed) to be taken nasally if a seizure was lasting more than five minutes.[15]

12. M.A.'s physician prescribed midazolam, a liquid narcotic, because it is fast acting.[16] Controlling seizures quickly is important to prevent brain damage and death.[17]

13. Because it is a narcotic, midazolam is a controlled medication.[18]

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[5] *Id.* at 549.
[6] *Id.*
[7] Ex. 25 at H.
[8] *Id.*
[9] Ex. 4.
[10] *Id.*
[11] *Id.*; Ex. 11 at 249; Ex. 12.
[12] Ex. 7.
[13] Ex. 8; Ex. 25 at H.
[14] Ex. 11; Ex. 12 at 384.
[15] *Id.* at 265.
[16] Ex. 25 at D;
[17] *Id.*
[18] Ex. 10; Test. of Natalie Zeleznikar.

14. It is Spectrum's policy to "take every step possible to avoid handling or administering liquid narcotics."[19] Spectrum's procedure is to notify hospice providers and pharmacies that narcotics must not be in liquid form but rather, for example, suppositories or melt-away tabs.[20]

15. On December 21, 2020, Bascue destroyed M.A.'s midazolam.[21]

16. Bascue destroyed M.A.'s midazolam because she was worried about staff not being protected by Spectrum if the drug were diverted (stolen).[22] Bascue also knew that it was Spectrum's policy to not store or administer such medications, if possible.[23]

17. Bascue did not document her concerns with the presence of the midazolam, nor did she communicate her concerns with the prescribing doctor, other hospice staff, the pharmacy, M.A., or M.A.'s children. She did not request an alternative drug from M.A.'s physician.[24]

18. M.A.'s physician could have found an alternative option for her if the Facility had informed him that it did not want to store or administer the midazolam.[25]

19. On February 2, 2021, M.A. had a seizure that lasted longer than five minutes.[26] The midazolam was not available to stop M.A.'s seizure.[27]

20. On February 2, 2021, due to M.A.'s extreme discomfort from her seizure, she was transferred to hospital in Ely where the seizure was controlled with intravenously administered Versed.[28]

21. On February 6, 2021, M.A. died at hospital due to her seizure.[29]

22. It is not clear that the timely administration of the midazolam would have changed the outcome for M.A., but it likely would have stopped her seizure sooner.[30]

23. Any finding of fact more properly deemed a conclusion of law is hereby adopted as such. Any conclusion of law more properly deemed a finding of fact is hereby adopted as such. Any material facts in the memorandum that do not appear in these findings of fact are incorporated herein by reference.

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[19] Ex. 17 at 531.
[20] *Id.*
[21] Ex. 13; Ex. 25 at H.
[22] Ex. 25 at H.
[23] *Id.*
[24] *Id.* (Bascue did have a subordinate witness the destruction of the drug. Ex. 10.)
[25] Ex. 25 at D.
[26] Ex. 12.
[27] Ex. 6 at 59.
[28] *Id.*
[29] Ex. 3; Ex, 25 at D.
[30] Ex. 25 at D.

Based upon the foregoing findings of fact, the Administrative Law Judge makes the following:

CONCLUSIONS OF LAW

1. The Commissioner of Health and the Administrative Law Judge have jurisdiction to consider this matter pursuant to Minn. Stat. §§ 14.50, 14.57-.62, 144A.474, 245A.07, 626.557, subp. 9d(f) (2020).

2. Spectrum received due, proper, and timely notice of the Department's action and the right to appeal pursuant to Minn. Stat. §§ 144A.474, 245A.07, 626.557.

3. The Department has complied with all procedural requirements of rule and law.

4. Spectrum is a comprehensive "home care provider" under Minn. Stat. § 144A.43 (2020).

5. "A comprehensive home care provider who provides medication management services must develop, implement, and maintain current written medication management policies and procedures."[31]

6. Spectrum failed to implement its written medication management policies and procedures when the executive director failed to document and raise her concerns about M.A.'s prescription for midazolam with the physician who prescribed it, other hospice staff, or M.A., and when she unilaterally destroyed the medication.

7. The Department may issue fines for violations. Fines are based on the level and scope of the violation.[32] A level 3 violation is one "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."[33] The fine for a level 3 violation is $3,000.[34]

8. Spectrum's failure to implement its written medication management policies and procedures may have led to serious injury or impairment of M.A. and had the potential to lead to her death. Thus, the Department's finding that the violation was level 3, and the resulting $3,000 fine, was appropriate.

[31] Minn. Stat. § 144A.4792, subd. 1(b) (2020).
[32] Minn. Stat. § 144A.474, subd. 11(a).
[33] *Id*. at subd. 11(b)(iii).
[34] *Id.* at subd. 11(a).

9. Maltreatment of a vulnerable adult may be caused by neglect.[35] Neglect includes "[t]he failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to…health care…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."[36]

10. Spectrum neglected M.A. when her prescribed seizure medication was not available when needed following its destruction by the executive director.

11. The fine for maltreatment, under Minn. Stat. § 144A.474, is $1,000.[37] The Commissioner may impose a $5,000 fine, however, when the maltreatment consists of death.[38]

12. The evidence does not demonstrate that M.A. died as a result of the failure to timely provide the prescribed seizure medication. Therefore, the substantiated maltreatment may result in a fine of $1,000, not $5,000.

Based upon the foregoing findings of fact and conclusions of law, and for the reasons set forth in the memorandum below, the Administrative Law Judge makes the following:

RECOMMENDATION

The Department appropriately determined Spectrum failed to implement its medication management policy when the executive director destroyed M.A.'s medication without discussing her concerns about the medication with appropriate parties. The Department assigned an appropriate fine for this violation.

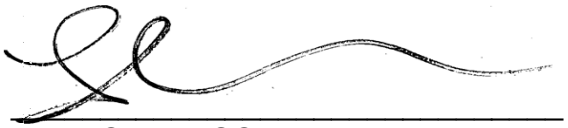
The Department also appropriately determined Spectrum was responsible for maltreatment of M.A. by neglect when a drug M.A. required in an emergency was not available because it had been destroyed, without proper consultation or notice, by the executive director of the Facility. However, because it is just as likely that M.A. would have died had she timely received the medication, the fine for the maltreatment can only be $1,000.

Therefore, the Administrative Law Judge respectfully requests the Commissioner **AFFIRM** the $3,000 fine issued to Spectrum on March 24, 2021, and **RESCIND** the

[35] Minn. Stat. § 626.5572, subd. 15 (2020).
[36] *Id.* at subd. 17(a) (2020).
[37] Minn. Stat. § 144A.474, subd. 11(a).
[38] *Id.*

$5,000 fine for the maltreatment. The Commissioner should require no more than a $1,000 fine for the maltreatment by neglect.

Dated: September 21, 2021



JIM MORTENSON
Administrative Law Judge

Reported: Digitally Recorded; No transcript prepared

NOTICE

This Report is a recommendation, not a final decision. The Commissioner will make the final decision after a review of the record. The Commissioner may adopt, reject or modify the findings of fact, conclusions of law, and recommendations. Under Minn. Stat. § 14.61 (2020), the Commissioner may not make a final decision until this Report has been made available to the parties to the proceeding for at least ten days. An opportunity must be afforded to each party adversely affected by this Report to file exceptions and present argument to the Commissioner. Parties should contact the Commissioner of the Minnesota Department of Health, 85 East Seventh Place, P.O. Box 64975, St. Paul, MN 55164, to learn the procedure for filing exceptions or presenting argument.

If the Commissioner fails to issue a final decision within 90 days of the close of the record, this Report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a (2020). The record closes upon the filing of exceptions to the Report and the presentation of argument to the Commissioner, or upon the expiration of the deadline for doing so. The Commissioner must notify the parties and the Administrative Law Judge of the date on which the record closes.

Under Minn. Stat. § 14.62, subd. 1 (2020), the agency is required to serve a final decision upon each party and the Administrative Law Judge by first class mail or as otherwise provided by law.

MEMORANDUM

The Department of Health is required to investigate complaints "alleging that a home care provider has violated or is currently violating a requirement of [Minn. Stat.] sections 144A.43 to 144A.482.[39] A home care provider is:

> [A]n individual, organization, association, corporation, unit of government, or other entity that is regularly engaged in the delivery of at least one home

[39] Minn. Stat. § 144A.474, subd. 2(f).

> care service, directly in a client's home for a fee and who has a valid current temporary license or license issued under [Minn. Stat.] sections 144A.43 to 144A.482.[40]

On March 4, 2021, following M.A.'s death in an Ely, Minnesota hospital, the Department began an investigation which was completed on March 17, 2021.[41] It was alleged in a complaint to the Department that Bascue neglected M.A. when Bascue detroyed M.A.'s anti-seizure medication, resulting in the medication not being available when needed by M.A.[42] The Department's investigator, Peggy Boeck, RN, conducted a thorough review of M.A.'s medical records, Spectrum's policies, and interviewed multiple persons who were involved in M.A.'s care. The result was a detailed report, the imposition of a fine of $3,000 for failure to implement a medication management system, and the imposition of a $5,000 fine for substantiated maltreatment by neglect consisting of death or serious injury to M.A. by Spectrum.

In this appeal of the Department's findings, the Department carries the burden of proof that the violations, including maltreatment, occurred, and that appropriate fines were assessed.[43] The standard the Department must meet is a preponderance of the evidence.[44] A "preponderance of the evidence" means that the ultimate facts must be established by a greater weight of the evidence.[45] A fact must be of a greater or more convincing effect and lead you to believe that it is more likely that the claim is true than not true.[46]

The Department established that a violation of Minn. Stat. § 144A.4792 (2020) occurred. That law requires a home care provider that provides medication management services to implement its written policies and procedures on medication management. To "implement" means to "carry out, accomplish."[47] Spectrum's policies, as noted above, required staff to bring concerns about medications to the attention of "the prescriber and pharmacy, education of the client and/or the client's representative, and additional training for staff or other appropriate actions" as well as documenting these concerns and actions.[48] This did not occur here. The executive director, Bascue, made a unilateral decision which was counter to the written policy. Her intent is irrelevant. The failure to follow a reasonable policy designed to balance the needs of the caregiver and the client was a violation of the statute.

Fines for statutory violations are determined by the level and scope of the violation in question. Minn. Stat. § 144A.474 sets forth the levels as follows:

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[40] Minn. Stat. § 144A.43, subd. 4.
[41] Ex. 15.
[42] *Id.* at 448.
[43] *See, Schaffer ex rel. Schaffer v. Weast*, 546 U.S. 49, 57, 126 S.Ct. 528, 534 (2005).
[44] Minn. R. 1400.8608 (2021).
[45] 4 Michael K. Steenson & Peter B. Knapp, *Minnesota Practice* CIV JIG 14.15 (6th ed. 2014 & Oct. 2019 update).
[46] *State v. Wahlberg*, 296 N.W.2d 408, 418 (Minn. 1980).
[47] https://www.merriam-webster.com/dictionary/implement (last visited Sep. 13, 2021).
[48] Ex. 20 at 549.

(i) Level 1 is a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety;

(ii) Level 2 is a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death;

(iii) Level 3 is 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

(iv) Level 4 is a violation that results in serious injury, impairment, or death.[49]

Here, the evidence does not prove the destruction of the midazolam resulted in M.A.'s death. The evidence does show, however, that it had the potential to do so. In addition, the medication was prescribed to quickly address seizing, to protect the patient's brain function and life. Thus, the violation which led to the absence of the midazolam or a viable alternative reasonably led to harm to M.A.'s safety and health, and certainly had the potential to lead to serious injury, impairment, or death. Thus, the statutory fine for a level 3 violation - $3,000[50] – is appropriate.

The Department also established that maltreatment by neglect occurred. M.A. was prescribed a drug for seizures by her hospice doctor, and it was included in her care plan. Spectrum's executive director destroyed the drug. As a result, M.A. did not have the drug when she needed it. The destruction of M.A.'s midazolam resulted in a failure by her caregiver, Spectrum, to provide her with the medical care that was reasonably necessary according to her physician and care plan.

The executive director of the Facility may not have acted with bad intent, but her intent is not material. The evidence shows she exercised a judgment call when she determined to destroy M.A.'s midazolam. Her concern about the drug being diverted and the impact that could have on her staff was legitimate. But this does not excuse the neglect. Spectrum's reasonable policy to consult with and find alternatives to certain narcotics for clients under its care required staff to consult with the prescribing physician. This did not happen. The result was that M.A. lacked any drug to be timely delivered for her seizures. Thus, the Department proved its finding of substantiated maltreatment.

But the Department did not prove the $5,000 fine was appropriate. The Department concluded that the lack of midazolam resulted in M.A.'s death. This ignored the prescribing physician's statement that he was not sure the midazolam would have changed the outcome for M.A. Afterall, M.A. was on hospice care and was, overall, declining in health. While the evidence shows M.A.'s seizure directly led to her death (not,

[49] Minn. Stat. § 144A.474, subd. 11(b)(1).
[50] *Id.* at subd. 11(a).

as Spectrum argues, a stroke), the preponderance of the evidence – primarily the physician's statement - shows that she may have been destined for that outcome no matter what. Neither party called the physician to testify to clarify his statement to the investigator. Nor was any expert evidence put forward to prove a direct link to the lack of timely midazolam to M.A.'s death. So, while the Department's theory about the link between the failure to have the midazolam for M.A. and her death resulting from the seizure a few days later is reasonable, the prescribing physician's statement that the result might have been identical had the drug been available and timely administered puts the evidence in equipoise. In other words, the evidence in this case is equally balanced. Therefore, the Department failed to establish by a preponderance of the evidence that the maltreatment resulted in death. As a result, the fine for the maltreatment must be left at $1,000, pursuant to Minn. Stat. § 144.474, subd. 11(a).

For the foregoing reasons, the Administrative Law Judge respectfully recommends the Commissioner **AFFIRM** the violation and resulting $3,000 fine for Spectrum's failure to implement its medication management policy. Further, the Judge recommends the Commissioner **AFFIRM** the finding of maltreatment by neglect but **RESCIND** the $5,000 fine and replace it with the statutory $1,000 fine.

J. R. M.