



# Misappropriation of Narcotics in Assisted Living

**November 29, 2012**

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## Office of Caregiver Quality (OCQ)



**Department of Health Services  
Division of Quality Assurance  
Office of Caregiver Quality**

**Nora Mendoza  
FOCUS Conference  
November 2012**



# What is OCQ's Role and Responsibility?

Assist in providing Wisconsin's continuum of quality care to citizens by protecting vulnerable clients from misconduct in health care settings by:

- Approving, monitoring nurse aide training, testing & Nurse Aide Registry.
- Tracking nurse aides eligible to work in Wisconsin.
- Oversight of feeding assistant training programs.



## What is OCQ's Role and Responsibility?

Assist in providing Wisconsin's continuum of quality care to citizens by protecting vulnerable clients from misconduct in health care settings by:

- Investigating reports of caregiver misconduct.
- Tracking caregivers with findings of misconduct.
- Completing caregiver background checks for DQA entity owners, operators and non-client residents.



# Who and What Do We Investigate?

## Who?

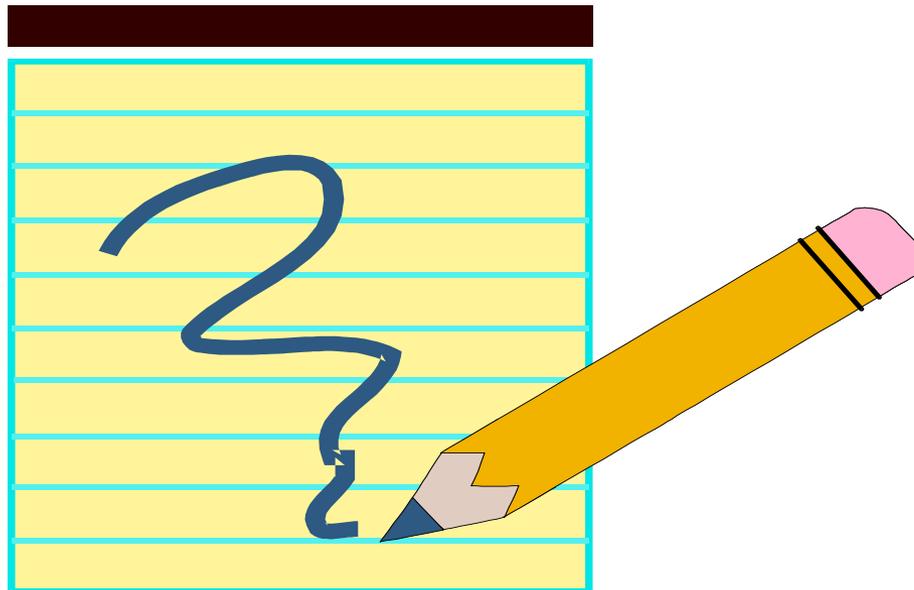
Investigate Caregivers

## What?

Abuse, Neglect, Misappropriation



# Entity Investigation and Reporting Requirements





# What Are the Entity's Investigative Responsibilities?



All DQA-regulated entities **MUST** conduct a thorough investigation and document their findings for all reported incidents.



## Written Procedures?

DQA regulated entities are required to develop written procedures indicating:

- How staff will report incidents;
- How investigations will be completed;
- How staff will be trained; and
- How residents will be informed.



## Protection of Clients

IMMEDIATELY upon learning of the incident, the entity must take necessary steps to protect clients from possible further incidents of misconduct or injury, while the matter is pending.



## The Entity Must Report an Incident to DQA When:

- ❖ The entity has reasonable cause to believe they have sufficient evidence, or another regulatory authority could obtain the evidence, to show the alleged incident occurred.

**AND**

- ❖ The entity has reasonable cause to believe the incident meets, or could meet, the definition of abuse, neglect or misappropriation.

**REPORT TO DQA**



# Reporting Incidents to DQA

All providers

Use Incident Report (F-62447)

Mail or Fax F-62447 (postmarked) upon notification of the incident within:

- 7 calendar days
- Incidents involving non-credentialed staff, credentialed staff and others - send to the Office of Caregiver Quality



## OCQ Investigation Guidelines

### Complete Investigation

- ☞ Case may be completed by Intake Investigator or if further investigation is needed, assigned to CPI 3 (Field Investigator).
- ☞ Investigate (on-site, in-person interview, telephone interview). Interview witnesses, accused, staff, others as needed.
- ☞ Field investigators may conduct joint investigation with DQA Program survey staff.
- ☞ Investigators submit written report regarding their findings and a recommendation is made whether or not to substantiate.



## When Finding of Caregiver Misconduct Is Substantiated:

- ❖ Written notice that DHS determined caregiver misconduct occurred and substantiated finding under their name will be placed on the Wisconsin Caregiver Misconduct Registry.
- ❖ <http://www.dhs.wisconsin.gov/caregiver/misconduct.HTM>
- ❖ Individual can appeal the substantiated finding.



## When Finding of Caregiver Misconduct Is Substantiated (continued):

- ✓ Nurse aides cannot be employed, in any capacity, in federally-certified nursing homes or, in most incidents, ICFs/MR.
- ✓ An individual cannot be employed as a caregiver in DHS-regulated facilities unless approved through the Rehabilitation Review Process.



## January-June 2012 By Facility Type

25.0%	1	RCAC
75.0%	3	CBRF
0.0%	0	AFH

## January-June 2012 By Region

NERO	2	4	50.0%
SERO	0	4	0.0%
SRO	1	4	25.0%
WRO	1	4	25.0%



## 2012 Examples

### Substantiated 1/10/12

- On 3/7/11, Program Director reported to the Police Department someone had been opening Fentanyl packages, taking the Fentanyl patch itself out, then using the patch and putting it back into the original package. Program Director said they discovered three Fentanyl packages with scotch tape to make them look like they were never opened. Program Director reported the Fentanyl patches in question are prescribed to a resident of the facility. Program Director turned the three tampered Fentanyl packages over to the Police Department as evidence. **NOTE:** Additional incidents of tampering and use of Caregiver's Fentanyl patches for the dates of 7/2/11 and 8/20/11 were reported to the Police Department and included under the same Case number. On 11/29/11, Caregiver admitted to Police Investigator that she was taking and using Fentanyl patches prescribed to resident without the resident's consent. (CBRF)

### Substantiated 2/10/12

- On December 27, 2011, caregiver was taken off rotation for passing medications for that day for further training because of a medication error discovered from earlier on December 27, 2011. Caregiver was interviewed by staff and stated that she did not make the medication error and she got the medication card to prove it. Caregiver took the medication card to Health Unit Coordinator who informed her that the facility had a photocopy of the pill in the bubble pack from earlier. Caregiver stated that she was being framed but when asked about the missing medication she said nothing. On December 29, 2011 the Administrator contacted the Police Department. When Police interviewed caregiver she initially denied the incident, but later admitted to stealing the pill. (CBRF)



## 2011 By Facility Type

22.2%	4	RCAC
35.3%	12	CBRF
5.9%	2	AFH

## 2011 By Region

NERO	8	18	44.4%
SERO	0	18	0.0%
SRO	5	18	27.8%
WRO	5	18	27.8%



## 2011 Examples

### **Substantiated 4/27/11**

Caregiver was accused of replacing hydrocodone pills with an over the counter medication in resident's medications. The Police Department investigated the case. Caregiver confessed to the Police Department that she took 8 hydrocodone pills belonging to a resident. (AFH)

### **Substantiated 6/7/11**

Personal Care Worker admitted to documenting on the Medication Administration Record of a resident that she was giving PRN hydrocodone to resident, when she was really taking the medication herself. (CBRF)

### **Substantiated 7/13/11**

Caregiver accused of taking a number of Hydrocodone tablets from resident. Police department called On May 13, 2011, Officer interviewed caregiver about obtaining prescription medication by fraudulent means. Caregiver confessed that she took four refills of resident's Hydrocodone tablets and there were 90 pills per refill resulting in a total of 360 pills that she had taken for herself. Caregiver stated that none of these pills were ever administered to the resident. Upon completion of the interview, caregiver was booked by the Officer on a charge of obtaining a controlled substance by fraud, contrary to sec. 961.43(1)(a), 939.50(3)(h) Wis. Stats., a Class H Felony. (CBRF)



## Wisconsin Caregiver Program Questions

- **Caregiver Background Checks?** Contact DQA Office of Caregiver Quality at (608) 261-8319 or [DHSCaregiverIntake@wi.gov](mailto:DHSCaregiverIntake@wi.gov)
- **DOJ Criminal History info.?** Call DOJ Crime Info. Bureau at (608) 266-7780
- **Rehab Review Process?** Contact DHS Office of Legal Counsel at (608) 266-1900 or [RehabRC@dhs.state.wi.us](mailto:RehabRC@dhs.state.wi.us)
- **Misconduct Reporting?** Contact DQA Office of Caregiver Quality at (608) 261-8319 or [DHSCaregiverIntake@wi.gov](mailto:DHSCaregiverIntake@wi.gov)
- **Substantiated Findings?** Verify status on [www.pearsonvue.com](http://www.pearsonvue.com) (Wisconsin Nurse Aides)
- See the website for *The Wisconsin Caregiver Program Manual*, forms, brochures & more!

[www.dhs.wisconsin.gov/caregiver/index.htm](http://www.dhs.wisconsin.gov/caregiver/index.htm)



## Important Resources

<http://dhs.wisconsin.gov/caregiver/index.htm>

- Wisconsin Statutes; ss. 50.65 & 146, Stats.
- Wisconsin Administrative Code
  - Ch. DHS 12 (background checks)
  - Ch. DHS 13 (caregiver investigations)

Office of Caregiver Quality

PO Box 2969

Madison, WI 53701-2969

608-261-8319

[DHSCaregiverIntake@wi.gov](mailto:DHSCaregiverIntake@wi.gov)



# Misappropriation of Controlled Substances: Impact on Assisted Living Facilities

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November 29, 2012



## DQA Regulated Facility Responsibility

### Community Based Residential Facilities

\*DHS 83.12 Investigation, notification, and reporting requirements

\*DHS 83.12 (2) (a) Caregiver: 1. ....take immediate steps to ensure the safety of all residents.

\*DHS 83.12 (2) (a) Caregiver: 2. investigate and document any allegations of misappropriation of property (i.e., medications).  
....report (if necessary) the incident to the department within 7 calendar days...



## DQA Regulated Facility Responsibility

### Community Based Residential Facilities

\*DHS 83.12 (2)(b) Non-Caregiver or resident

elder abuse reporting requirements under s.46.90, Stats., or the adult at risk requirements under s. 55.043, Stats., whichever is applicable.

\*DHS 83.12(2)(c) Other reporting

Filing a report under sub.(1) or (2) does not relieve the licensee or other person of any obligation to report an incident to any other authority...



# DQA Regulated Facility Responsibility

## Community Based Residential Facilities

\*DHS 83.32 Right of residents

\*DHS 83.32(3)(d) Freedom from mistreatment: Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property.

\*DHS 83.32(3)(h) Receive medication: Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner.....

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## DQA Regulated Facility Responsibility

Adult Family Home

\*DHS 88.10(3) Resident rights

\*DHS 88.10(3)(m) Freedom of abuse: To be free from.....misappropriation of property.

\*DHS 88.10(3)(q) Medication: To receive all prescribed medication in the dosage and at the interval prescribed by the resident's physician,...



## DQA Regulated Facility Responsibility

Residential Care Apartment Complex

\*DHS 89.34 Rights of tenants

\*DHS 89.34(16) Medications: ...when the facility is managing the medications, to receive all prescribed medications at the dosage and at the interval prescribed by the tenant's physician...

\*DHS 89.34(18) Freedom from abuse: To be free from ...misappropriation of property by the facility, its staff or any service provider under contract with the facility.



## How To Be Compliant

Entities are required to develop written procedures specifying:

1. How and to whom staff are to report incidents;
2. How internal investigations will be completed;
3. How staff will be trained on the procedures related to allegations of caregiver misconduct; and
4. How residents will be informed of those procedures.



## Compliance

\*Immediately upon learning of an incident, you must take the necessary steps to protect clients from possible subsequent incidents of misconduct or injury.

\*You are encouraged to notify local law enforcement authorities of any situation where there is a potential criminal offense.



## Compliance

Immediately conduct a thorough internal investigation and document the findings for each allegation or incident. A thorough internal investigation may include:

- \*Collecting and preserving evidence;
- \*Interviewing alleged victims and witnesses;
- \*Collecting other corroborating/disproving evidence;
- \*Involving other regulatory authorities;
- \*Documenting each step taken during the internal investigation.



## Example of Serious Violation

A caregiver witnessed a co-worker slipping a resident's narcotic pain medication into her pocket. Another caregiver witnessed the co-worker putting the resident's medication "in her mouth". The incidents were reported to the manager but no investigation was conducted.



## Example of Serious Violation

The licensee refilled and stole 50 bottles of narcotic pain medication prescribed for a resident with developmental disabilities who was unable to communicate. When investigated by law enforcement, the licensee confessed she had never given the pain medication to the resident in the 8 years she provided care.



## Example of Serious Violation

A facility did not investigate and report to the department when a resident's Fentanyl patches (prescribed for pain management) were missing.



## Example of Serious Violation

Steps were not taken to promptly replace a resident's narcotic pain medication after 30 pills were stolen. The facility did not report to the Department and had not contacted law enforcement. After the resident was without pain medication for 6 days, the resident's family notified police in an effort to authorize a replacement supply of the medications.



## What Can We Do as a Facility?

What , when, where, who?

What medication came in?

When did it come in?

Where did it go?

Who was responsible?



## What Can We Do as a Facility?

Specific Pearls: Criminals from outside

- \*Environment

- \*Double keys & Two staff

- \*Separated Storage

- \*Cameras

- \*Inventory Management

- \*General Observations



## What Can We Do as a Facility?

Specific Pearls: Staff/Others Stealing to Sell

- Limiting Access
- Intake Procedures
- PRN Supplies
- Follow up any complaint of something missing: Track and Trend
- Packaging Alterations
- Resident Responses



## What Can We Do as a Facility?

Specific Pearls: Staff/Others Stealing for Personal Use

- \*Staff/Other's Behaviors

- \*Resident Complaints of Different Looking/Tasting

- \*Patterns of Administration of PRNs

- \*Patterns of Ordering PRN: Limit who can order PRN

- \*Changes in medication losses over time

- \*Comments about hard times



## Contact Information

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Training Developed by the:  
University of Wisconsin Oshkosh  
Center for Career Development (CCDET)  
and  
Wisconsin Department of Health Services

Donna Cochems, CCDET



- Introduction
  - What is medication diversion?
  - Widespread problem
  - Why caregivers may be more susceptible
- Controlled Substances
- Commonly Abused Prescription Medications



- Observing Rules and Regulations
- Knowing Your Responsibilities
  - As a caregiver
  - As a supervisor/manager
- Recognizing Red Flags
  - What an employer can do
  - What an employee can do
- Developing Best Practices



- Wisconsin's Caregiver Law
  - Abuse, neglect, misappropriation
  - Enforced by DHS Division of Quality Assurance, DSPS
- Criminal Charges and Penalties
  - Theft, neglect, etc.
  - Enforced by local law enforcement and the WI Department of Justice



- Materials include a facilitator guide, participant guide, PPT
- Access the training material at:

<http://www.uwosh.edu/ccdet/caregiver/topical.htm>



PREVENT  PROTECT  PROMOTE  
*abuse/neglect* *clients* *dignity*

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