



Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: Recover Health			Report Number: H7185007	Date of Visit: June 7 and 8, 2017
Facility Address: 3400 1st Street North			Time of Visit: 2:00 p.m. to 4:30 p.m. 8:00 a.m. to 12:15 p.m.	Date Concluded: December 27, 2017
Facility City: St. Cloud			Investigator's Name and Title: Jane Aandal, RN, Special Investigator	
State: Minnesota	ZIP: 56303	County: Stearns		

HHA

Allegation(s):

It is alleged that a patient was neglected when a staff/alleged perpetrator worked with the patient while impaired. The patient's ileostomy and urostomy bags were overflowing. The patient was fearful and had difficulty sleeping since the night of the incident.

It is alleged that a patient was financially exploited when AP took a variety of the patient's medications.

It is alleged that a patient was abused when blood was found on syringes in the nurses' room, counter, floor, and sofa. The patient had bleeding noted in the patient's underwear later that night.

- State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence neglect is inconclusive. The alleged perpetrator's (AP) behaviors and slurred speech indicated the AP was impaired while working with the patient; however, staff emptied the patient's ileostomy and urostomy bags prior to them overflowing. The patient did have some difficulty sleeping after the night of the incident.

Based on a preponderance of evidence, financial exploitation did occur when the alleged perpetrator (AP) took a prescription bottle of diazepam belonging to the patient.

Based on a preponderance of evidence abuse did not occur. Blood was found on syringes in the nurses'

room, counter, floor, and couch. The patient's physical examination by the nurse and physician indicated the blood in the patient's underwear was not from trauma.

The patient was diagnosed with a metabolic disorder and severe intellectual disabilities. The patient communicated by making verbal noises. The patient had a gastrostomy-jejunostomy tube (a tube placed through the stomach and small bowel) used for medications. An intravenous central line for fluids, nutrition, and medications. An ileostomy (for bowel elimination) and a urostomy (for bladder elimination). The patient required close supervision 24 hours per day for safety due to impulsiveness and poor decision making.

The patient had a physician order for diazepam 5 milligrams (mg) once daily and 3 mg once daily for agitation.

The AP arrived at the patient's home to work a midnight to 7:00 a.m., shift. At approximately 3:35 a.m., the family was awakened in their bedroom by the AP standing by the bed talking with slurred speech. The AP then left the bedroom and went out to the kitchen. A family member followed the AP out to the kitchen and found several needles and syringes on the kitchen island, spilled oral and liquid medications on the counter and floor, and syringes on the floor. The AP then went to the refrigerator and put food in the microwave. At 4:21 a.m., the family member called their own private duty nurse and informed him/her of what had occurred. Another family member found the patient on the edge of the bed crying. At 4:41 a.m., a family member sent a text message to the private duty nurse to come to the house. In the nurses' room, the family found one syringe in the couch, one on the floor, and one on the counter. The family member found a needle on the end of the syringe with blood on it, and the AP placed the syringe into his/her backpack. At approximately 5:15 a.m., the family member noticed the patient's intravenous pump that contained the patient's midnight antibiotic was shut off. The family member restarted the pump and the patient received the antibiotic medication. At 5:35 a.m., the private duty nurse arrived at the house and the AP was seated on the couch in the nurses' room confused and had slurred speech. The private duty nurse asked the AP if s/he had taken any mind-altering drugs and the AP replied no. The private duty nurse told the AP to leave the house and s/he would cover the rest of the shift. The private duty nurse then called the sheriff's department. While the private duty nurse was on the phone with dispatch, s/he was told there had been a car accident at the end of the road involving the AP.

The private duty nurse was interviewed and stated s/he had emptied 1,950 cubic centimeters (cc) of urine from the urostomy bag that holds 2,000 cc and emptied 950 cc of stool from the ileostomy bag prior to them backing up or overflowing. The private duty nurse stated s/he worked with the patient on the sixth night after the incident and the patient did have difficulty sleeping.

Attempts to reach the AP for an interview were unsuccessful.

The private duty nurse and the agency staff assessed the patient in the morning and found no physical injuries. A speck of blood was found in the patient's underwear with no trauma noted.

The physician performed a physical examination three days later and found no trauma to the anal area.

The police report indicated the AP had been in a car accident at the end of the road and had hit a boulder. During the police search, the AP was found with a prescription bottle of diazepam belonging to the patient. In addition, laboratory results identified the AP had diazepam in his/her system. The police forwarded the case to the county attorney and 4th degree driving under the influence charges were filed against the AP.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

- Abuse Neglect Financial Exploitation
- Substantiated Not Substantiated Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the Individual(s) and/or Facility is responsible for the

- Abuse Neglect Financial Exploitation. This determination was based on the following:

The nurse was trained on the facility's vulnerable adult and financial exploitation policies and procedures.

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.

Compliance:

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) – Compliance Met
The facility was found to be in compliance with State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483). No state licensing orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statutes for Chapters 144 &144A were not met.

State licensing orders were issued: Yes No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 9 - Financial exploitation

"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;

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- Medical Records
- Medication Administration Records
- Physician Orders
- Physician Progress Notes
- Care Plan Records
- Laboratory and X-ray Reports

Other pertinent medical records:

- Hospital Records
- Police Report

Additional facility records:

- Staff Time Sheets, Schedules, etc.
- Facility Internal Investigation Reports
- Personnel Records/Background Check, etc.
- Facility Policies and Procedures

Number of additional resident(s) reviewed: One

Were residents selected based on the allegation(s)? Yes No N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

Yes No N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with reporter(s) Yes No N/A

Specify: _____

If unable to contact reporter, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:
_____	_____	_____	_____	_____	_____

Interview with family: Yes No N/A Specify: _____

Did you interview the resident(s) identified in allegation:

Yes No N/A Specify: Attempted

Did you interview additional residents? Yes No

Total number of resident interviews: Zero

Interview with staff: Yes No N/A Specify: _____

Tennessee Warnings

Tennessee Warning given as required: Yes No

Total number of staff interviews: Six

Physician Interviewed: Yes No

Nurse Practitioner Interviewed: Yes No

Physician Assistant Interviewed: Yes No

Interview with Alleged Perpetrator(s): Yes No N/A Specify: Unable to reach

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:
06/16/2017	1:00 p.m.	06/21/2017	10:50 a.m.	06/22/2017	3:35 p.m.

If unable to contact was subpoena issued: Yes, date subpoena was issued 06/11/2017 No

Were contacts made with any of the following:

Emergency Personnel Police Officers Medical Examiner Other: Specify _____

Facility Name: Recover Health

Report Number: H7185007

Observations were conducted related to:

- Nursing Services
- Other: The patient's home

Was any involved equipment inspected: Yes No N/A

Was equipment being operated in safe manner: Yes No N/A

Were photographs taken: Yes No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Nursing

St. Cloud Police Department

Stearns County Attorney

St. Cloud City Attorney



Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 7015 1660 0000 4149 8051

October 19, 2017

Ms. Dawn Rund, Administrator
Recover Health
3400 1st Street North
Saint Cloud, MN 56303

RE: Complaint Number H7185008

Dear Ms. Rund :

A complaint investigation (H7185008) of the Home Care Provider named above was completed on August 15, 2017, for the purpose of assessing compliance with state licensing regulations. At the time of the investigation, the investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these regulations. These state licensing orders are issued in accordance with Minnesota Statutes Sections 144A.43 to 144A.482.

State licensing orders are delineated on the attached State Form. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by."

A written plan for correction of licensing orders is not required. Per Minnesota State Statute 144A.474 Subd. 8(c), the home care provider must document in the provider's records any action taken to comply with the correction order. A copy of this document of the home care provider's action may be requested at future surveys.


A licensed home care provider may request a correction order reconsideration regarding any correction order issued to the provider. The reconsideration must be in writing and received within 15 calendar days. Reconsiderations should be addressed to:

Ms. Michelle Ness, Assistant Director
Office of Health Facility Complaints
Minnesota Department of Health
P.O. Box 64970
St. Paul, MN 55164-0970

Recover Health
October 19, 2017
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It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Kate Johnston". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Kate JohnSTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Home Health Care Assisted Living File
County Adult Protection
Office of Ombudsman
MN Department of Human Services

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H02312	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/15/2017
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NAME OF PROVIDER OR SUPPLIER RECOVER HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 3400 1ST STREET NORTH SAINT CLOUD, MN 56303
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(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
0 000	<p>Initial Comments</p> <p>A complaint investigation was conducted to investigate complaint #H7185007 and #H7185008. The following correction order is issued related to H7185007.</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2)</p>	
0 325	<p>144A.44, Subd. 1(14) Free From Maltreatment</p> <p>Subdivision 1. Statement of rights. A person who receives home care services has these rights:</p>	0 325		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H02312	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/15/2017
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0 325	<p>Continued From page 1</p> <p>(14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act;</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a patient was free from maltreatment of financial exploitation for one of two patients, (P1), reviewed when P1's diazepam medication was taken by registered nurse (RN)-H for his own personal use.</p> <p>Findings include:</p> <p>The agency's abuse, neglect, and misappropriation investigation policy dated 5/14, indicated Recover Health would comply with the Vulnerable Adult Act. The agency's employee handbook indicated staff were not to consume drugs before their shift or while on duty. Violation of this would result in immediate termination. The patient's medications were for their use only and staff were not to take any prescription or nonprescription medication belonging to the patient.</p> <p>P1's medical record was reviewed. P1's face sheet indicated P1 was diagnosed with a metabolic disorder and severe intellectual disabilities.</p> <p>P1's letter of medical necessity dated 11/25/16, indicated P1 had a gastrostomy-jejunostomy tube (a tube placed through the stomach and small bowel) used for medications. An intravenous central line used for fluids, nutrition, and medications. An ileostomy (for bowel elimination)</p>	0 325		

Minnesota Department of Health

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0 325	<p>Continued From page 2</p> <p>and a urostomy (for bladder elimination). P1 required close supervision 24 hours per day for safety due to impulsiveness and poor decision making.</p> <p>P1 had a physician's order dated 4/12/17, for diazepam 5 milligrams (mg) once daily and 3 mg once daily for agitation.</p> <p>An interview with family member (FM)-I was conducted on 6/7/17, at 3:01 p.m. FM-A stated she used private duty nursing and supplemented P1's cares with nursing services from the agency. FM-A stated on 4/15/17, RN-H started his shift at midnight until 7:00 a.m. FM-A stated their bedroom was at one end of the house and P1 had his bedroom at the other end of the house next to the nurses' room. FM-A stated at 3:35 a.m. she was awakened by RN-H standing next to her bed talking with slurred speech. RN-H then left the bedroom and went out to the kitchen. FM-A followed RN-H out to the kitchen and found several needles and syringes on the kitchen island, unidentified spilled oral and liquid medications on the counter and floor, and syringes on the floor. RN-H then went to the refrigerator and put food in the microwave. At 4:21 a.m. FM-A called RN-E private duty nurse case manager and told her what had occurred at the house. FM-A stated another family member found P1 seated on the edge of the bed crying. At 4:41 a.m. a family member texted RN-E and told her to come to the house. FM-A stated in the nurses' room she found three syringes, one in the couch, one on the floor, and one on the counter. FM-A stated she observed a needle on the end of the syringe with blood on it, and RN-H placed the syringe into his backpack.</p> <p>An interview with RN-E was conducted on 6/9/17,</p>	0 325		

Minnesota Department of Health

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0 325	Continued From page 3 at 10:07 a.m. RN-E stated she arrived at P1's house on 4/15/17, at 5:35 a.m. RN-E stated RN-H was on the couch in the nurses' room confused and had very slurred speech. RN-E asked RN-H if he had taken any mind altering drugs and RN-H stated no. RN-E told RN-H she would cover the rest of his shift and told him to leave the house. RN-E then called the sheriff's department. While RN-E was on the phone with dispatch, she was told there had been a car accident at the end of the road. RN-E stated RN-H had hit a boulder with his car. The police report indicated RN-H had a car accident after leaving P1's residence on 4/15/17. RN-H was found with a prescription bottle of diazepam belonging to P1. In addition, laboratory results identified that RN-H had diazepam in his system. TIME PERIOD FOR CORRECTION: Twenty one (21) days	0 325		