MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Prairie River Home Care Inc.	H8056057	March 27, 2017
Facility Address:	**Time of Visit:**	**Date Concluded:**
25 1st Avenue NE Suite 100	9:45 a.m. to 2:30 p.m.	June 27, 2017
Facility City:	**Investigator's Name and Title:**	
Buffalo	Deborah Neuberger, RN, Special Investigator	

State:	ZIP:	County:
Minnesota	55313	Wright

☒ **HHA**

Allegation(s):
It is alleged that a client was financially exploited when the alleged perpetrator (AP), took the client's oxycodone for his/her own use.

- ☒ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
- ☒ 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, financial exploitation occurred when the alleged perpetrator (AP) took two oxycodone pills from the client's medication bottle.

The client's diagnoses included falls and diabetes. The client had physician's orders for home health aide care, three times a week, for assistance with bathing and personal care. The AP provided the home health aide care on the day of the incident.

During an interview, the client's family member stated the client had oxycodone in the home, to be used as needed for pain. The client had not been using the medication recently. At one point, date unknown, some of the medication went missing, so on the day of the theft, the family member placed a number of the client's oxycodone pills in a bottle above the refrigerator. The family member then left the home for about 20 minutes, and when s/he returned, ten of the pills were gone. The AP was the only person who had been in the home. The family member immediately called the police and the agency.

Interviews with agency staff revealed the agency took immediate action upon learning of the allegation. The agency suspended the AP and called law enforcement.

The police report revealed law enforcement interviewed the AP on the day of the incident, and the AP admitted s/he took two oxycodone pills from the client without the client's permission. The AP had two oxycodone tablets in his/her possession at the time of the law enforcement interview. The case was

referred for criminal charges.

During an interview, the AP stated s/he took two of the client's oxycodone pills on the day of the incident, without the client's permission. The AP stated s/he took the tablets because s/he was having pain, was struggling in life, and impulsively took them. The AP denied taking pills from the client's supply on any previous day. The AP did not provide any explanation for the difference between the ten pills which were missing and the two which were found in his/her possession and s/he admitted taking.

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 AP is responsible for the financial exploitation, because although the agency had policies in place related to client protections and the AP was trained on those policies, the AP did not follow those policies. Instead, the AP chose to take the client's property for the AP's use without the client's knowledge or permission.

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 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.

Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484) - Compliance Not Met
The requirements under Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484) were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

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

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues 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:

Facility Corrective Action:

The facility took the following corrective action(s):

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

☒ Care Guide

☒ Medication Administration Records

- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Therapy and/or Ancillary Services Records
- [x] ADL (Activities of Daily Living) Flow Sheets
- [x] Service Plan

Other pertinent medical records:

- [x] Police Report

Additional facility records:

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

Number of additional resident(s) reviewed: Four

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 complainant(s) ○ Yes ○ No ◉ N/A

Specify: _____

If unable to contact complainant, 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: Family declined the interview.

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: One

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Three

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☒ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Nursing Services

☒ Dignity/Privacy Issues

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

The Office of Ombudsman for Long-Term Care

Buffalo Police Department

Wright County Attorney

Buffalo City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248056	A. BUILDING _____ B. WING _____	C 07/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE RIVER HOME CARE INC	25 1ST AVENUE NE STE 100 BUFFALO, MN 55313

(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
G 000	INITIAL COMMENTS A complaint investigation was conducted to investigate case #H8056057. As a result, the following deficiency is issued.	G 000		
G 105	484.10(b)(3) EXERCISE OF RIGHTS AND RESPECT FOR PROP The patient has the right to have his or her property treated with respect. This STANDARD is not met as evidenced by: Based on interview and document review, the agency failed to ensure that a client's property treated with respect for 1 of 5 clients reviewed, Client #1 (C1), when Home Health Aide (HHA)-D took two tablets of C1's Oxycodone for her own use, without C1's permission. Findings include: Medical record review revealed that C1's admission to the agency occurred 1/13/2017. C1's diagnoses included falls and diabetes. C1's physician orders also included Home Health Aide care, three times per week. C1's Home Health Aide Clinical Note, dated 2/13/2017, revealed that HHA-D assisted the client with bathing, dressing, and toileting on 2/13/2017. During an interview on 3/28/2017 at 9:05 a.m., C1's family member stated C1 had Oxycodone pain medication she used as needed for pain in the home, but she had not been using it. The HHA-D worked in C1's home three days a week. At one point, exact date unknown, some of the Oxycodone pain medication, went missing. On 2/13/2017, the family member counted out some	G 105		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 105	Continued From page 1	G 105		

of the Oxycodone and placed some of C1's Oxycodone in a bottle in the kitchen. He left C1's home, then came back 20 minutes later and 10 of the Oxycodone in the bottle were missing. HHA-D was the only person in the home during that time. The family member immediately called the agency and the police to report the theft.

During an interview on 3/27/2017 at 10:10 a.m., General Manager (GM)-A stated C1's family member called her on 2/13/2017 to report that 10 of C1's Oxycodone 5 mg. medication was missing. GM-A called the police and she and the police officer interviewed HHA-D at about 1:00 p.m. on 2/13/2017. During the interview, HHA-D emptied her pockets and two Oxycodone pills fell out of her pocket. HHA -D admitted she took two or three of C1's Oxycodone medication that morning, without C1's permission.

During an interview on 4/6/2017 at 1:15 p.m., HHA-D stated she took two of C1's Oxycodone pills on an unknown date without C1's permission. The medication was in a cabinet above the refrigerator in C1's home and she saw them and took some. HHA-D stated she took them because she was having pain and was struggling in life, so she impulsively took some of the pills. HHA-D expressed remorse and stated she is getting treatment to try to pull her life back together. HHA-D stated the police were involved and she was told she would get information related to charges being filed, but she had not heard anything yet.

A police report dated, occurred 1/23/2017 - 2/13/2017, revealed that during the law enforcement interview with HHA-D on 2/13/2017, HHA-D admitted taking two Oxycodone pills from

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G 105	Continued From page 2 C1 on 2/13/2017. The case was submitted for charges. The agency policy titled Vulnerability Assessment and Reporting - Definitions, dated 3/26/2015, and provided by agency staff, revealed: Financial Exploitation means...In the absence of legal authority a person: willfully uses, withholds, or disposes of funds or property of a vulnerable adult...Maltreatment means...financial exploitation.	G 105		

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	H03190	A. BUILDING: _____ B. WING _____	C 07/17/2017

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0 000	Initial Comments A complaint investigation was conducted to investigate complaint #H8056057. The following correction order is issued.	0 000	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. 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.	
0 325	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (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;	0 325		

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0 325	Continued From page 1 This MN Requirement is not met as evidenced by: Based on interview and document review, the agency failed to ensure that a client was free from maltreatment for 1 of 5 clients reviewed, Client #1 (C1), when Home Health Aide (HHA)-D, financially exploited C1 when she took C1's Oxycodone for her own use, without C1's permission. This practice resulted in a level two violation (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), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Medical record review revealed that C1's admission to the agency occurred 1/13/2017. C1's diagnoses included falls and diabetes. C1's physician orders also included Home Health Aide care, three times per week. C1's Home Health Aide Clinical Note, dated 2/13/2017, revealed that HHA-D assisted the client with bathing, dressing, and toileting on 2/13/2017. During an interview on 3/28/2017 at 9:05 a.m., C1's family member stated C1 had Oxycodone pain medication she used as needed for pain in the home, but she had not been using it. The HHA-D worked in C1's home three days a week. At one point, exact date unknown, some of the Oxycodone pain medication, went missing. On	0 325		

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0 325	Continued From page 2 2/13/2017, the family member counted out some of the Oxycodone and placed some of C1's Oxycodone in a bottle in the kitchen. He left C1's home, then came back 20 minutes later and 10 of the Oxycodone in the bottle were missing. HHA-D was the only person in the home during that time. The family member immediately called the agency and the police to report the theft. During an interview on 3/27/2017 at 10:10 a.m., General Manager (GM)-A stated C1's family member called her on 2/13/2017 to report that 10 of C1's Oxycodone 5 mg. medication was missing. GM-A called the police and she and the police officer interviewed HHA-D at about 1:00 p.m. on 2/13/2017. During the interview, HHA-D emptied her pockets and two Oxycodone pills fell out of her pocket. HHA -D admitted she took two or three of C1's Oxycodone medication that morning, without C1's permission. During an interview on 4/6/2017 at 1:15 p.m., HHA-D stated she took two of C1's Oxycodone pills on an unknown date without C1's permission. The medication was in a cabinet above the refrigerator in C1's home and she saw them and took some. HHA-D stated she took them because she was having pain and was struggling in life, so she impulsively took some of the pills. HHA-D expressed remorse and stated she is getting treatment to try to pull her life back together. HHA-D stated the police were involved and she was told she would get information related to charges being filed, but she had not heard anything yet. A police report dated, occurred 1/23/2017 - 2/13/2017, revealed that during the law enforcement interview with HHA-D on 2/13/2017, HHA-D admitted taking two Oxycodone pills from	0 325		

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0 325	Continued From page 3 C1 on 2/13/2017. The case was submitted for charges. The agency policy titled Vulnerability Assessment and Reporting - Definitions, dated 3/26/2015, and provided by agency staff, revealed: Financial Exploitation means...In the absence of legal authority a person: willfully uses, withholds, or disposes of funds or property of a vulnerable adult...Maltreatment means...financial exploitation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 325		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

October 26, 2017

Ms. Judy Figge, Administrator
Prairie River Home Care Inc
25 1st Avenue Northeast Suite 100
Buffalo, MN 55313

RE: Complaint Number H8056057 Licensing Follow-up and Post Certification Revisit (PCR)

Dear Ms. Figge:

On September 19, 2017, an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a revisit related to a deficiency and license order issued on July 17, 2017.

The investigator found that the deficiency and licensing order issued at the time of the investigation were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Office of Health Facility Complaints (OHFC) File