



Protecting, Maintaining and Improving the Health of All Minnesotans

January 3, 2020

Administrator
International Quality Homecare
3900 Fairway Place Nw
Rochester, MN 55901

RE: Project Number H8078023C, H8078024C, H8078025C, H8078026C, H8078027C, H8078028C,
H8078029C

Dear Administrator:

On December 19, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance.

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 with any questions related to this letter.

Sincerely,

A handwritten signature in black ink, appearing to read 'Douglas Larson'.

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

January 3, 2020

Administrator
International Quality Homecare
3900 Fairway Place NW
Rochester, MN 55901

Re: Project Number H8078023C, H8078024C, H8078025C, H8078026C, H8078027C, H8078028C, H8078029C

Dear Administrator:

On December 19, 2019, staff of the Minnesota Department of Health completed a follow-up survey of your agency to determine correction of orders found on the survey completed on November 5, 2019. At this time these correction orders were found corrected.

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.

Sincerely,

A handwritten signature in black ink, appearing to read 'Douglas Larson'.

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Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail # 7016 2070 0000 7235 0808

December 5, 2019

Administrator
International Quality Homecare
3261 19th St Northwest
Rochester, MN 55901

RE: Project Number H8078023C, H8078024C, H8078025C, H8078026C, H8078027C, H8078028C, H8078029C

Dear Administrator:

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

A partial extended survey was completed at your agency on November 5, 2019 for the purpose of assessing compliance with Federal certification regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division noted one or more deficiencies and found that your agency was not in substantial compliance with the participation requirements. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

At the time of this survey it was determined that the following Condition(s) of Participation were found not met:

G 406 -- 42 CFR 484.50 -- Patient Rights

Since these deficiencies limit your capacity to provide adequate care to patients, you must respond within ten calendar (10) days with your plan of correction. The plan must be specific, realistic, include the date certain for correction of each deficiency and be signed and dated by the administrator or other authorized official of the agency. An acceptable plan of correction must contain the following elements:

The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;

- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- What correction action(s) will be accomplished for those patients found to have been affected by the deficient practice;

- How you will identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements, i.e., what quality assurance program will be put into place;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correction will be completed.

If your agency has failed to achieve compliance by the date certain, sanctions including but not limited to fines of up to \$10,000.00 per day, may be recommended for imposition to the Centers for Medicare and Medicaid Services (CMS) Regional Office. Informal dispute resolution (IDR) for the cited deficiencies will not delay imposition of any recommended enforcement actions. A change in the seriousness of the noncompliance at the time of the revisit may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

The plan of correction should be directed to:

**Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348**

Failure to submit an acceptable written plan of correction of Federal deficiencies within ten calendar days of your receipt of this notice may result in imposition of sanctions, decertification and/or a loss of Federal reimbursement. Additionally, your continued certification is contingent upon corrective action. If, upon a revisit within forty five (45) days of the survey exit date, correction is not ascertained, we will have no recourse except to recommend to the Centers for Medicare and Medicaid Services Chicago Region V Office that sanctions be imposed.

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

HOME HEALTH AIDE TRAINING AND/OR COMPETENCY EVALUATION PROHIBITION

Federal Law, as specified in 42 CFR 484.36 (a) (2), prohibits any home health agency from offering and/or conducting a home health aide training and/or competency evaluation program which, within the previous two years, has been found:

- (A) Out of compliance with requirements of 42 CFR 484.36 (a) or (b);
- (B) To permit an individual that does not meet the definition of “home health aide” as specified in §484.4 to furnish home health aide services (with the exception of licensed health professionals and volunteers);
- (C) Has been subject to an extended (or partial extended) survey as a result of having been found to have furnished substandard care (or for other reasons at the discretion of CMS or the State);
- (D) Has been assessed a civil monetary penalty of not less than \$5,000 as an intermediate sanction;
- (E) Has been found to have compliance deficiencies that endanger the health and safety of the HHA’s patients and has had a temporary management appointed to oversee the management of the HHA;
- (F) Has had all or part of its Medicare payments suspended; or
- (G) Under any Federal or State law within the 2-year period beginning on October 1, 1988--
 - (1) Has had its participation in the Medicare program terminated;
 - (2) Has been assessed a penalty of not less than \$5,000 for deficiencies in Federal or State standards for HHAs;
 - (3) Was subject to a suspension of Medicare payments to which it otherwise would have been entitled;
 - (4) Had operated under a temporary management that was appointed to oversee the operation of the HHA and to ensure the health and safety of the HHA’s patients; or
 - (5) Was closed or had its residents transferred by the State.

Therefore, International Quality Homecare is precluded from conducting a home health aide training and/or competency evaluation program for a period of two years beginning November 5, 2019.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.745, you have one opportunity to dispute condition-level survey

International Quality Homecare

December 5, 2019

Page 4

findings warranting a sanction through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Home Health Agency Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies.

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of sanctions.

If you have any questions on this matter, please do not hesitate to call.

Sincerely,



Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248078	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2019
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NAME OF PROVIDER OR SUPPLIER INTERNATIONAL QUALITY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3261 19TH ST NORTHWEST ROCHESTER, MN 55901
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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) COMPLETION DATE
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G 000	<p>INITIAL COMMENTS</p> <p>An abbreviated survey was initiated at International Quality Homecare on 10/29/19, 11/1/19, 11/2/19, 11/4/19 and 11/5/19, to investigate complaints. As a result a partial extended survey was conducted. The Agency is not in compliance with requirements at 42 CFR, Part 484, Requirements for Home Health Agencies.</p> <p>H8078024C was unsubstantiated H8078026C was substantiated at G430 H8078025C was substantiated at G430, G488 H8078023C was substantiated at G430, G488 H8078027C was substantiated at G430, H8078028C was substantiated at G430, G488 H8078029C was substantiated at G430, G488</p> <p>In addition, the Condition of Participation at 484.50, Patient Rights was found NOT to be in compliance.</p> <p>Federal Law as specified in 42 CFR 484.80 (f)(3), prohibits any home health agency to offer and/or conduct home health aide training and/or competency testing which, within the previous two years has been subjected to an extended (or partially extended) survey as a result of having been found to have a Federal Condition of Participation not met at the extended survey.</p>	G 000		
G 406	<p>Patient rights CFR(s): 484.50</p> <p>Condition of participation: Patient rights. The patient and representative (if any), have the right to be informed of the patient's rights in a language and manner the individual understands.</p>	G 406	<p><i>approved Kat 12/18/19 with attached addendum.</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gayne Kalunan Director of Compliance TITLE: _____ (X6) DATE: 12/13/19

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.

	<p>refuse to talk to them." At this time, services are still being provided to him.</p> <p>e. P7:</p> <p>1) <i>The employee no longer works for us. At the time she was here, other clients that she worked with had been surveyed to see if there were any issues with her. They reported there were no inappropriate interactions or difficulties with her.</i></p> <p>2) <i>IQHC continues to provide services to this client.</i></p> <p>3. How will you identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>a. <i>We will be completing a Quarterly sampling (a percentage) of our clients in which they will be contacted by phone for a survey on how services are being provided and the interactions of the employees with them.</i></p> <p>b. <i>Any surveys that may reflect a problem will be addressed closer to determine if there is an issue happening.</i></p> <p>c. <i>Any response that may reflect a problem will be further investigated and evaluated then.</i></p> <p>4. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</p> <p>a. <i>All staff are being re-trained in the VA laws and reporting, and the Bill of rights.</i></p> <p>b. <i>The compliance department has a direct line into the Director and the Manager in which employees and/or clients can call with concerns, reporting, or questions.</i></p> <p>c. Regular contact made by the offices of IQHC with the clients to check on services <i>Any concerns will be forwarded and addressed by the Compliance Dept.</i></p> <p>5. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements, i.e. what quality assurance program will be put in place:</p> <p>a. <i>The quality assurance individual in our compliance department will be separate from the other compliance and will be involved in the surveying of clients and follow up for looking into ones needing further assistance.</i></p> <p>b. <i>The compliance department will be meeting on a quarterly basis to review data collected and review for issues, patterns, etc.</i></p> <p>6. Title of person/s responsible for implementing the acceptable plan of Correction: <i>Director of Compliance</i> <i>Compliance Manager</i> <i>Quality Assurance Manager</i></p>	<p>1/17/ 2020</p>
<p>G 430</p>	<p>CFR 484.50 Patient Rights: Condition of Participation The patient and representative (if any), have the right to be informed of the patient's rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights. Based on interview and document review the home health agency failed to meet the CoP at 484.50, Patient Rights. The HHA failed to ensure 6 of 7 patients were free from verbal abuse, neglect of care, or</p>	<p>1/17/ 2020</p>

	<p>3) IQHC continues to provide services to him.</p> <p>e. P7:</p> <p>1) The employee no longer works for us. At the time she was here, other clients that she worked with had been surveyed to see if there were any issues with her. They reported there were no inappropriate interactions or difficulties with her.</p> <p>2) IQHC continues to provide services to this client.</p> <p>3. How will you identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>a. We will be completing a Quarterly sampling (a percentage) of our clients in which they will be contacted by phone for a survey on how services are being provided and the interactions of the employees with them.</p> <p>b. Any surveys that may reflect a problem will be addressed closer to determine if there is an issue happening.</p> <p>c. Any response that may reflect a problem will be further investigated and evaluated then.</p> <p>4. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</p> <p>a. All staff are being re-trained in the VA laws and reporting, and the Bill of rights.</p> <p>b. The compliance department has a direct line into the Director and the Manager in which employees and/or clients can call with concerns, reporting, or questions.</p> <p>c. Regular contact by the offices of IQHC with the clients to check on services. Any concerns can then be addressed.</p> <p>5. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements, i.e. what quality assurance program will be put in place:</p> <p>a. The quality assurance individual in our compliance department will be separate from the other compliance and will be involved in the surveying of clients and follow up for looking into ones needing further assistance.</p> <p>b. The compliance department will be meeting on a quarterly basis to review data collected and review for issues, patterns, etc.</p> <p>6. Title of person/s responsible for implementing the acceptable plan of Correction: Director of Compliance Compliance Manager Quality Assurance Manager</p>	<p>1/17/2020</p>
<p>G 488</p>	<p>CFR 484.50 Patient Rights: Condition of Participation The patient and representative (if any), have the right to be informed of the patient's rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights. Based on interview and document review the home health agency failed to meet the CoP at 484.50, Patient Rights. The HHA failed to ensure 6 of 7 patients were free from verbal abuse, neglect of care, or financial exploitation, including failure to protect and thoroughly investigate. In addition, the agency failed to report immediately to the State Agency (SA) allegations of verbal abuse, neglect of care, and</p>	<p>1/17/2020</p>

	<p>4. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none">a. <i>All staff are being re-trained in the VA laws and reporting, and the Bill of rights.</i>b. <i>The compliance department has a direct line into the Director and the Manager in which employees and/or clients can call with concerns, reporting, or questions.</i>c. <i>Regular contact by the offices of IQHC with the clients to check on services. Any concerns can then be addressed.</i> <p>5. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements, i.e. what quality assurance program will be put in place:</p> <ul style="list-style-type: none">a. <i>The quality assurance individual in our compliance department will be separate from the other compliance and will be involved in the surveying of clients and follow up for looking into ones needing further assistance.</i>b. <i>The compliance department will be meeting on a quarterly basis to review data collected and review for issues, patterns, etc.</i> <p>6. Title of person/s responsible for implementing the acceptable plan of Correction: <i>Director of Compliance</i> <i>Compliance Manager</i> <i>Quality Assurance Manager</i></p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248078	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/05/2019
NAME OF PROVIDER OR SUPPLIER INTERNATIONAL QUALITY HOMECARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3261 19TH ST NORTHWEST ROCHESTER, MN 55901		
(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 406	Continued From page 1 The HHA must protect and promote the exercise of these rights. This CONDITION is not met as evidenced by: Based on interview and document review, the home health agency (HHA) failed to meet the Condition of Participation at 484.50, Patient Rights. The HHA failed to ensure 6 of 7 patients (P1, P2, P3, P5, P6, P7) were free from verbal abuse, neglect of care or financial exploitation, including failure to protect and thoroughly investigate. In addition, the agency failed to report immediately to the State Agency (SA) allegations of verbal abuse, neglect of care, and financial exploitation 5 of 7 patients (P1, P2, P4 P5, P7) reviewed for allegations of abuse. The cumulative effect of this system failure resulted in the agency's inability to ensure patient rights were protected and promoted. Findings include: Refer to G430: Based on interview and document review, the agency failed to ensure 6 of 7 patients (P1, P2, P3, P5, P6, P7) were free from verbal abuse, neglect of care or financial exploitation, including failure to protect and thoroughly investigate. Refer to G488: The HHA failed to report immediately to the State Agency (SA) allegations of verbal abuse, neglect of care, and financial exploitation 5 of 7 patients (P1, P2, P4, P5, P7) reviewed for allegations of abuse. This had the potential to affect all current patients and any future patients served by the agency.	G 406			
G 430	Be free from abuse CFR(s): 484.50(c)(2)	G 430			

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G 430	<p>Continued From page 2</p> <p>Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property; This ELEMENT is not met as evidenced by: Based on interview and document review, the agency failed to ensure 6 of 7 patients (P1, P2, P3, P5, P6, P7) were free from verbal abuse, neglect of care or financial exploitation, including failure to protect and thoroughly investigate. This had the potential to affect all patients served by this agency.</p> <p>Findings include:</p> <p>P1's Plans of Care (POC) dated 7/16- 9/13/19 and 9/14- 11/2/19, indicated P1's start of care (SOC) was 5/22/18. P1's diagnoses included venous insufficiency, lymphedema and atrial fibrillation. The POC also indicated P1 was to receive skilled nursing visits 0-3 visits per week for 60 days for wound care, education about medication use and nursing staff to clean, dress, wrap lower extremities, monitor lower legs for any open areas. P1's POC also indicated P1 was oriented in relation to mental status.</p> <p>Review of a Common Entry Point Intake Form dated 10/14/19, indicated P1 had reported to the compliance department of the agency that registered nurse (RN)-A threatened to slap him, and he feared that she was going to. The report indicated P1 had reported RN-A had visited him on 8/16/19, after he had returned home from the hospital on 8/12/19. P1 stated he was supposed to go to rehab (rehabilitation), but had explained to RN-A he was not going to go because he had too much work to do around the house. P1 reported at that time, RN-A stated that someone</p>	G 430		

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G 430	<p>Continued From page 3</p> <p>should smack him across the face for turning that down, and P1 reported he felt RN-A was actually going to slap him. Further, the report indicated RN-A had been removed from P1's home and would no longer provide cares for P1.</p> <p>The agency's Internal Investigation Report, identified the following through interviews the agency had conducted: On 10/14/19, the compliance manager (CM)-A interviewed P1. P1 stated to CM-A, "The incident or close encounter was because I was supposed to do rehab. I mentioned that I couldn't go and she [RN-A] said to me, 'you ought to have your face slapped' for turning that down." P1 reported, "Her [RN-A] face was red, eyes enlarged, and I could smell her breath. I thought she was going to slap me. She is argumentative and once had to leave me to sit in her car for about ten minutes, I think it was to calm down. Every time she comes here, she raises her voice and is demanding." P1 reported the incident occurred on Friday August 16 (2019). P1 had further stated he felt threatened and stated, "Any minute I thought her hand was going to hit my face. I'm not sure why she didn't do it." According to the report CM-A asked if there were any additional incidents to where he felt threatened and P1 stated, "She cannot take no for an answer. She would get mad and argumentative. She would talk down to me and I don't like to be talked down to. We would argue so much that I would tell her to listen, get my legs done here and when you are done, get the hell out of here."</p> <p>The report indicated on 10/14/19, CM-A had interviewed RN-B. RN-B had reported, "A while ago [RN-A] told me she had gotten into an argument with [P1]."</p>	G 430		

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G 430	<p>Continued From page 4</p> <p>The documents indicated on 10/15/19, CM-A had interviewed RN-A. CM-A had asked RN-A about P1 and RN-A stated, "I went in to do his wound changes. He was angry with me. It started when I was training [licensed practical nurse (LPN)-A] and we didn't have enough supplies. We went into his closet and both of us were condensing his supplies. He was angry with me because it would take him months to find things." Documentaion indicated CM-A had asked RN-A about the day P1 stated he was supposed to go to for rehab and RN-A stated, "It was Mayo. It was good. [RN-B] and I both told him that this is bad. You need to go to rehab. One day I walked in and he was very angry. He threatened me saying, 'Just get in here and change my fucking wounds and get out.' I told him, 'you do not have to talk to me like that.' He yelled at me to just get in here and change my wounds. I went out to my car about five minutes to collect myself. I came back in and gave short answers, yes and no."</p> <p>The documents indicated on 10/17/19, CM-A had interviewed LPN-A. The documents indicated LPN-A had reported P1 told her RN-A had said she [RN-A] had half the audacity to smack him across the face.</p> <p>The Internal Investigation Report identified recommendations of compliance regarding the results of the investigation: "At the time of this report [RN-A] has been removed from giving any cares to [P1]. It is recommended that [RN-A] receive a write up for her actions in this event and review training on vulnerable adult and treatment to minors as well as boundaries. [RN-A] shall remain removed from [P1's] home.</p>	G 430		
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G 430	<p>Continued From page 5</p> <p>During interview on 10/29/19 at 1:07 p.m., P1 stated the incident with RN-A had occurred on Friday 8/16/19, when RN-A came to change the dressings for wounds on his legs. P1 stated, "The hospital wanted me to go to rehab, but I told her I couldn't go. She got real perturbed saying, 'You mean to tell me you turned that down?' When I told her 'Yeah I have too much to do' she got mad and said, 'You ought a have your face slapped', she was close to me, her face was real red, I could smell her breath and her eyes were as big as quarters. She Looked angry. I thought she was going to slap me, but she didn't. I think she had intent. Another time she got mad, walked out of the house and sat in her car fifteen minutes and I did not know if she was going to change the dressings on my legs. About a month or two ago she went into my bedroom, went through my medical supplies and tried to consolidate them. I had it in order so I told her to get the hell out of there, I have everything in order. I told her, 'Change the dressings since that is what you are here for.' She never asked permission to go into the bedroom. About every time she came out here, her and I would get in an argument. She was very negative, not very professional in actions or words. Most of the time she would start arguing about anything I would say. It got to be a pain in the neck. At first I did not report it to the home health agency, as I did not know what she was going to do. About August 27th, I mentioned it to the nurse that comes on Tuesdays. I told her that [RN-A] threatened to slap me and I asked for a different nurse to come on Fridays. She said, 'You should report this.' I called someone at the [agency] and reported it to them because the nurse on Tuesday told me to."</p> <p>The agency Schedule Verification for P1 identified</p>	G 430		

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G 430	<p>Continued From page 6 on Friday 8/16/19, RN-A had provided services for P1. Start time of 10:33 a.m. and end time of 12:13 p.m.</p> <p>During interview on 11/1/19 at 2:57 p.m., LPN-A stated, "When I came into the office one day [RN-A] was freaking out because State was here. She said 'I know it's about [P1], because me and him got into an argument'. [RN-A] said she had to step away and go out and have a cigarette, because he made her mad. I just tried to calm her down because investigations happen all the time, because I did not know what happened. RN-A told me, him and her got into a verbal argument. The next time I went to visit [P1], he said they got into a verbal argument, she slammed the door and went outside to smoke and he said she had the half the audacity to smack him across the face, something like that." LPN-A had stated the day RN-A had informed her she had a verbal argument with P1, LPN-A had informed RN-B and did not know who else to report it to at the time. LPN-A stated, "I asked a friend what to do, [RN-B] and I talked to my friend, because it was bothering me and [RN-B] a lot." "I did not know who to talk to, as I did not know what staff here does what?" "My friend said we need to report it that is when we reported it." "I asked [RN-B] who she was going to report it to and she said she was going to email [administrator].</p> <p>An agency email dated Friday 10/11/19, at 4:35 p.m. sent from RN-B to the administrator, included RN-B had informed the administrator there were separate vulnerable adult and child situations related to RN-A. The first being P1. "She threatened to slap him and he actually feared she was going to. He would like to make a report with his details." The administrator had</p>	G 430		

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G 430	<p>Continued From page 7</p> <p>forwarded the email to CM-A on Friday 10/11/19, at 9:12 p.m.</p> <p>During interview on 11/4/19 at 1:20 p.m., RN-A stated, "[P1] and I have a history, we got along when I first started. My biggest problem with him, was he would tell me what the doctor wanted, but I never saw papers. He directed how to wrap his legs. One time I went in with another nurse [LPN-A] and we did not have all the supplies and I knew he had dressings in his bedroom. I asked if I could go back there. We found one small box of dressing sponges in a box. We made the comment we should condense these [supply boxes] as these are a home for cock roaches. We started to put things together, tossed things out of the room and he said don't be going in there rearranging things, so we stopped and took the supplies we needed and I showed [LPN-A] how to change the dressings on his wounds. The next time I went in there I basically got yelled at, because we had condensed things into a box and he said it would take months to reorganize it. I told him I apologize and it was not my intention to do that. We will have to make a concession that you have all the supplies in the living room so I don't have to go into the bedroom and get supplies." RN-A stated another time she went out to P1's house she was in a dress and P1 had stated, "Why are you dressed like that." RN-A said, "I had a dress on that day as [P1's] house is warm. I have an anxiety issue. I told [P1] I need a moment and he needed a moment and I left the house. I walked outside, went in the car and called the office. I reported to the branch office coordinator what had gone on. I told her I needed a moment and would go back in and dress his legs. That is what I did. I did not say much to him. I was short and said yes or no answers and did</p>	G 430		

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G 430	<p>Continued From page 8</p> <p>what he told me. He had come out of the hospital and they recommended he do some PT [physical therapy] and OT [occupational therapy]. I said to him, 'You could have made a better decision' and that I was disappointed in his decision. I know it got a little bit heated." RN-A stated, "You have heard about the three altercations I had with him. I felt uncomfortable working with him because he did not like me. As a team we tried to talk to him about changing days of the week [when P1's service visits were scheduled], as with scheduling we were trying to schedule all [city] in one day to save time for the branch running to clients. He would not work out a compromise. Anytime I tried to talk to him it would turn into an argument, so we would make the days he was scheduled work." In addition, during the interview RN-A stated she had not heard from the agency what the recommendations from the investigation were, nor had she been provided any education.</p> <p>During interview on 11/1/19 at 10:15 a.m., CM-A stated RN-A had not been written up or had the training as documented in the investigation recommendations.</p> <p>P2's current POC dated 10/14-12/12/19, indicated P2's SOC was 12/18/18. P2's diagnoses included hypertension, type two diabetes, hypothyroidism and a very low level of personal hygiene. The POC also indicated P2 was to receive skilled nursing visits 0-1 visits per week for 60 days for management of medications.</p> <p>An agency email dated Friday 10/11/19 at 4:35 p.m., sent from RN-B to the administrator, included RN-B reporting there were separate vulnerable adult and child situations related to RN-A. The other being P2, who RN-A yelled at</p>	G 430		

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G 430	<p>Continued From page 9 and told him how disgusting he lives. The administrator had forwarded the email to CM-A on Friday 10/11/19, at 9:12 p.m.</p> <p>Review of a Common Entry Point Intake Form dated 10/14/19, indicated it was reported to the compliance department of the agency that P2 had been yelled at by RN-A about how disgusting he lives. The report indicated P2 stated about two to three months ago RN-A had been abusive to him, not physically but verbally. P2 stated he did recall what was said but did not feel comfortable speaking to me (CM-A). P2 stated he believed the problem had been resolved because RN-A had not been coming there anymore.</p> <p>The agency Internal Investigation Report identified the following through interviews the agency had conducted: On 10/14/19, CM-A had interviewed P2. P2 was asked to explain the incident that occurred involving him and RN-A. P2 stated, "Well I am not really sure, it may be a personality conflict. I have been here 9 years. I have had a lot of nurses. [RN-A] has been abusive to me, not physically, just verbally. After a while, I didn't think I should have to go through this, so I called the Ombudsman." When asked what RN-A had said to him, P2 stated, "Yeah, I remember. I am not real comfortable sharing with you what she said. I just don't think I should be treated like that."</p> <p>On 10/14/19, CM-A had interviewed RN-B. RN-B reported she had overheard RN-A speak of how disgusting P2 lives. RN-B stated she had heard from LPN-A that RN-A had yelled at P2.</p> <p>On 10/15/19, CM-A had interviewed RN-A. CM-A had asked RN-A about P2. The documentation</p>	G 430		

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G 430	<p>Continued From page 10</p> <p>indicated RN-A stated, "I have seen [P2] last week. His room is pungent. I get stopped by residents that talk about how bad he smells. He has been receiving eviction notices. He is a slob." CM-A asked RN-A if she had mentioned that to P2</p> <p>'in so many words,' RN-A said, "Yes I have. He throws his food and his incontinent pads not in the trash, but on the floor. His hair is knotted. His beard and clothes have dry milk and frosting. All of the homemakers have been told that he would shower another day. His floor is so sticky that your shoes stick to the floor. He called his social worker saying that he did not want me anymore."</p> <p>On 10/17/19, CM-A had interviewed LPN-A. LPN-A stated, "He [P2] says that she [RN-A] yells at him and calls him disgusting. Says she [RN-A] is rude ...she uses higher words I don't understand. Does not treat him with respect or dignity."</p> <p>The Internal Investigation Report also identified recommendations for compliance: "At the time of this report [RN-A] has been removed from giving any cares to [P2]. It is recommended that [RN-A] receive a write up for her actions in this event and review training on vulnerable adult and treatment to minors as well as boundaries. [RN-A] shall remain removed from [P2's] home."</p> <p>During interview on 11/1/19, at 1:27 p.m. P2 stated, "I reported this a month or two ago, it had been a while I was being verbally abused with her language. I reported to the Ombudsman and he talked to someone at the [agency]. The Ombudsman talked to someone at [agency] and they stopped sending [RN-A]. [RN-A] came one time a week to set up meds, order meds and pick</p>	G 430		

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G 430	<p>Continued From page 11</p> <p>up meds. She was verbally abusive about things. She talked about the condition of my apartment, personal condition and I told her I was taking steps to correct this. The basic thing she said was there is an aroma in your apartment. She harped on that a lot. I have a urinary incontinence problem and I wear undergarments to help. It's a medical problem and it's a real frustrating thing for me. It is terrible to be criticized by someone who is a health care worker. I have lived here for nine years and had a lot of nurses, and never had someone treated me like that. She should be aware of personal feelings I have and medical problems. The nurses told me before 'don't take a shower unless someone is in the apartment', so I waited each week for the housekeeper to be there when I took shower in case something happened. [RN-A] was complaining I was not taking care of my personal hygiene well enough, I have a body odor." "I said well I am taking a shower two to three times a week when the housekeeper was here. I felt I was being abused verbally by what she said. I thought the things she said were not necessary."</p> <p>During interview on 11/1/19, at 2:57 p.m., LPN-A stated before she started providing cares for P2, RN-A had told her, "How disgusting he is. That he pisses all over himself and the furniture. There is food everywhere. He is an extremely intelligent man but does not have any hygiene." LPN-A stated RN-A had stated, "We are not allowed to carry anything into the apartment with us. You go in there, you grab his pill thing and you walk out. You set up medication, take it back to him, he will look at them close up and put them away, he will sign paper and leave." "She said not to let him even use my pen." LPN-A stated RN-A had gone to P2's apartment on 10/8/19, to provide service</p>	G 430			

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G 430	<p>Continued From page 12</p> <p>for P2, as she was not able to work and had to take the day off." LPN-A stated, she had called P2 on 10/10/19, to see how he was doing and to make sure the visit went ok. LPN-A stated, "[RN-A] and [P2] had verbal arguments and he does not feel he is treated properly. She belittles him and does not treat him with any dignity or respect."</p> <p>During interview on 11/4/19, at 1:44 p.m. RN-A stated, "[P2] had a urine problem and threw his incontinent products on the floor. I did talk to him and said this was kind of disrespectful even for the homemakers. He should try to throw briefs in the garbage instead of towards the garbage can. I tried to talk to him about showering and doing so when homemakers are there. He agreed to that, but when following up with the homemakers on Monday, they report he would say he'd take one on Wednesday, and on Wednesday he'd say he would take one on Friday. So I did go in there and confront him. I told, 'You are 80 years old, I should not have to tell you need to take a shower.' I told him the homemakers had told me he was not showering. I know through the conversations we had I also said, 'I know they are going to be giving you an eviction notice.' I asked him to purchase his own blood pressure cuff because I did not want to use mine, which I use with other clients, because of his personal hygiene. There was one afternoon or morning I went in there to set up meds and I threw up, it made me physically sick. I told the social worker I could still set up meds if they couldn't find another nurse, but I couldn't do it in his apartment. The last time I went in there was when [LPN-A] was ill. I was supposed to set up meds. [P2] was going to go to a doctor appointment and he had dried milk on his beard, disheveled hair and dry frosting on</p>	G 430			

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G 430	<p>Continued From page 13</p> <p>his shirt. I suggested he clean up before goes to see the doctor. He becomes very defensive. He said, 'it's always you.' I stated, 'maybe you would want to know before you go see your primary doctor.' I know one time I lost my cool, I heard he was being evicted, had calls from daughter, the manager of the building and other residents saying can you take care of that stinking man. I was forceful, I was frustrated, I was everything in the world. I did yell at him, I said he was 80 years old and I should not have to come in and tell him he had to take a shower, or tell him 'this is why you are getting evicted.' This is why this is all happening, because of his poor personnel hygiene." RN-A also stated she still completes the Oasis assessments for P2, which requires her to make a visit to see P2. RN-A stated, "I try to limit myself with seeing P2, as I know he does not feel comfortable with me, and I don't feel comfortable with him." RN-A confirmed she is still having contact with P2 every 60 days. RN-A stated she recently provided medication set up and completed an Oasis assessment for P2.</p> <p>The agency Schedule Verification for P2, identified on Wednesday 10/9/19, RN-A had provided services for P2. Start time of 4:54 p.m. and end time of 5:45 p.m.</p> <p>During interview on 11/1/19, at 10:15 a.m., CM-A stated RN-A had not been written up or had the training as indicated on the investigation recommendations.</p> <p>During interview on 11/5/19, at 8:18 a.m., CM-A stated the last day RN-A had provided services for P2 was 10/9/19. CM-A verified with the branch office in Rochester that RN-A was still P2's case manager. CM-A stated he was not aware RN-A</p>	G 430			

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G 430	<p>Continued From page 14 was still assigned to be P2's case manager.</p> <p>During interview on 11/5/19, at 9:12 a.m., CM-A had called the branch office in Rochester and requested RN-B be assigned as case manager for P2 instead of RN-A.</p> <p>P3's current POC dated 9/2-11/25/19, indicated P3's SOC was 8/8/17. P3's diagnoses included illness and multiple sclerosis. The POC also indicated P3 was to receive skilled nursing visits 0-1 visits every week for 60 days for medication set up and assessment with three as needed visits for changes in health status and home health aide (HHA) 0-4 visits each week for 60 days to assist client with bathing, grooming, hygiene, dressing and transfers.</p> <p>Review of a Common Entry Point Intake Form dated 8/9/19, indicated a family member (FM)-C of home health aide (HHA)-B had called the agency office on the afternoon of 8/9/19, to report HHA-B had taken out a vehicle loan about a year ago and had the client, P3 co-sign for the vehicle. The family member FM-C became aware of it yesterday. FM-C also stated the car insurance was in P3's name and the client was paying the car insurance, not HHA-B.</p> <p>The agency Incident Report dated 8/9/19, at 3:45 p.m. identified the same as the Common Entry Point Intake Form.</p> <p>The agency Internal Investigation Report identified the following through interviews the agency had conducted: On 8/12/19, CM-A had interviewed P3. P3 stated she had driven her car to the car dealership to meet HHA-B and had co-signed for a car loan for HHA-B. P3 stated,</p>	G 430		

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G 430	<p>Continued From page 15</p> <p>"[HHA-B] had worse credit than me. She needed a car because she needed to get to all of her clients. That was very important to her." P3 stated HHA-B's FM-C was present at the car dealership.</p> <p>On 8/12/19, CM-A had interviewed HHA-B. HHA-B stated, in response to if she had P3 co-sign for a car loan, "Yes [P3] did, but I am paying for the vehicle." HHA-B stated this occurred "A year ago?" HHA-B stated, "My [FM-C] called [P3] and asked if she can help with the loan." HHA-B stated in response to who pays for the insurance, "I do." HHA-B stated in response to who's name is the insurance in, "It's in [P3], name, but I pay her for it." HHA-B stated FM-C was present at the car dealership, when P3 co-signed for the car loan.</p> <p>On 8/13/19, CM-A had interviewed detective (D)-D. D-D stated, "[HHA-B] admitted everything. She is not the loan payee. [P3] is paying."</p> <p>During interview on 10/29/19 at 2:50 p.m., P3 stated HHA-B did not have any credit and she needed a car. HHA-B's "family was there and told me to sign for the car loan." P3 stated this occurred back in 8/2018. P3 stated HHA-B has worked with her for five years. P3 stated HHA's FM-C would come and do HHA-B's job (give her a shower and do household work) when HHA-B could not make her scheduled visit due to being at another client's house. P3 stated FM-C was not an employee of the agency, but HHA-B was. P3 stated the agency was not aware of this. P3 stated she was the primary signer for the car loan and HHA-B was the co-signer and the insurance for the care was under her name. P3 stated, "[HHA-B] paid the car loan and I paid the insurance monthly." P3 stated HHA-B had</p>	G 430		

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G 430	<p>Continued From page 16</p> <p>approached her first to ask me to sign on the car loan. P3 stated HHA-B and FM-C had both asked for her to pay for the car insurance as they could not afford to due to having to pay insurance on another vehicle.</p> <p>During interview on 10/29/19, at 3:12 p.m., HHA-B stated FM-C was present when the car was purchased. The car loan place told me I needed a co-signer and FM-C stated why don't you ask P3. P3 co-signed on a loan for the car and the insurance was under P3's name. I paid the \$115.00 a month for the car insurance to her and I paid the car loan of \$279.00 a month. The car loan was in both of our names. HHA-B stated at the time of the incident she was an employee of the agency and had provided services of shower, cleaning house and shopping for P3 for about two years. HHA-B stated FM-C had gone to P3's home to do her job (as scheduled by the agency) for the day of providing a shower to P3, due to she was busy with another client and could not get there at the scheduled time. HHA-B stated the home care agency was not aware FM-C was at P3's home in place of her.</p> <p>During interview on 10/29/19, at 3:23 p.m. CM-A said in regards to whether the agency was aware FM-C had been in P3's home providing cares to P3 in place of HHA-B, CM-A said, "We were told that by the police department and determined it was not accurate. I am going to be honest with you. I don't believe any of this. The client (P3) did not report any of this until after she found out that [FM-C] had reported [HHA-B]. We found out about this through the police department, not through her [P3]. This was like a roller coaster going through liquidation of a divorce. He found out about the client co-signer on the car loan</p>	G 430		

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G 430	<p>Continued From page 17</p> <p>when the divorce started and decided to be a good citizen and report it to us. There was no proof he was ever in the house of the client."</p> <p>During interview on 11/4/19, at 10:20 a.m., RN-C stated FM-C had informed her of HHA-B having had P3 co-sign on a car loan and stated she knew P3 was also carrying the insurance. RN-C stated she had never heard of FM-C providing cares for P3 when HHA-B could not be there. "I know a lot of times [HHA-B] and [P3] made up their own schedule and we (agency) would not know about the changes or the times of when the visits were scheduled to be done with the changes."</p> <p>During interview on 11/4/19, at 2:39 p.m. FM-C stated at the car dealership HHA-B was dealing with obtaining the car loan. We were there all day long and I stepped out to have cigarettes. I don't know what happened and we drove out of there with a car. FM-C stated he did know who P3 was and stated, "I have been over to her place. We (HHA-B and self) were coming back into town and HHA-B had to be there, so we just stopped instead of dropping me off at home first. She did her work and we left. FM-C stated this occurred a couple of times. We would have to go or come from a doctor appointment or something and would stop at P3's house for HHA-B to do her job. FM-C confirmed he was not an employee of the agency at the time and when in P3's home had not provided cares for P3. FM-C stated he did not know how P3's name was on the title of the car P3 was not at the dealership the day the car was purchased. FM-C stated the insurance for the car was supposed to be transferred from his truck to the car and somehow P3's name ended up being on it.</p>	G 430		

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G 430	<p>Continued From page 18</p> <p>During interview on 11/5/19, at 9:59 a.m. CM-A stated he was not aware FM-C was present in P3's home when HHA-B was scheduled to be providing cares.</p> <p>During interview on 11/5/19, at 1:24 p.m. the administrator verified the date and time of the email regarding P1 and P2. The administrator stated she would not be surprised if the incidents did not get reported to the State Agency until Monday, "I don't think anybody is checking emails over the weekend. Everyone is a mandated reporter and I would have expected [RN-B] to have filled out an incident report and report the incidents to the State Agency." The administrator stated she was not aware what the recommendations of the investigations for P1 and P2 were in regards to RN-A.</p> <p>P5 financial exploitation P5's Personal Care Attendant (PCA) Service Plan dated 4/20/18, indicated P5 received PCA services 23 hrs per day. P5's Homecare Service Plan dated 4/20/18, indicated P5 received HHA services 3 visits daily.</p> <p>P5's POC for the certification period from 4/15-6/13/19, indicated P5 was admitted to the agency on 4/20/18, with diagnosis of early-onset cerebellar ataxia (symptoms of an inability to coordinate balance, gait, extremity and eye movements), type 2 diabetes, paroxysmal atrial fibrillation, hypertension, chronic obstructive pulmonary disease (COPD), and tobacco use. The POC also indicated P5 was to receive skilled nurse visits 1 per week and 3 as needed (PRN) visits for possible change in condition x 60 days, and home health aide (HHA) 0-3 visits each week x 60 days. P5's HHA care plan dated 7/6/19,</p>	G 430		

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G 430	<p>Continued From page 19</p> <p>identified the HHA would assist with bathing, dressing, grooming, transfers, and housekeeping. P5 was discharged from the agency on 6/7/19.</p> <p>Review of Common Entry Point Report Form dated 5/1/19, indicated P5's county case manager (CCM)-A reported that P5 had reported that [HHA-A], went to get [P5] quarters so he could do his laundry. [HHA-A] said she only took \$20.00 in quarters and brought that to [P5], but the slip said \$40.00. This happened in October, 2018.</p> <p>Review of HHA-A's Employee Coaching and Counseling Notice dated 12/29/18, indicated the following concerns were reported regarding [P5], employee borrows and doesn't return [P5's] small personal items: lighter, batteries, Tupperware. The concern violates the rule of conduct 8.1.27 borrowing or taking any clients money or personal property. Correction expected: [HHA-A] will not borrow any items from [P5].</p> <p>During phone interview on 11/5/19, at 9:44 a.m. CCM-A stated, "I am currently [P5's] case manager. [P5] told me over the phone on 5/1/19, that [HH-A] took 40 dollars in quarters and only gave 20 dollars back, this happened back in October, 2018."</p> <p>Although an attempt was made to phone HHA-A on 11/5/19 at 10:31 a.m., the phone mailbox was full and could not accept messages.</p> <p>During a phone interview on 11/5/19, at 12:34 p.m. P5 stated, "[HH-A] went to get me 20 dollars in quarters so I could do my laundry and she took 40 dollars, that's what the receipt said. I don't know where the extra 20 dollars went. I reported</p>	G 430		

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G 430	<p>Continued From page 20</p> <p>it to the [branch office coordinator (BOC)-A] at International Quality Home care, she said she would see what she could do about it. I never did get my 20 dollars back. I stopped services in June, 2019, because International didn't have enough people to cover the 24 hour care when I needed it."</p> <p>During a phone interview on 11/5/19 at 2:10 p.m., the BOC-A stated, "I am no longer the BOC, my employment ended January, 2019. I do remember there was a money issue with [P5] and [HHA-A], she denied it ever happening. I told them no one is working until we get this taken care of. I am not sure, but I feel like it was resolved, otherwise I would have followed up with it more." BOC-A further stated "I did not report this to the State Agency."</p> <p>During phone interview on 11/5/19, at 2:30 p.m. Assistant Branch Operation Coordinator (ABOC)-A stated, "I do remember [P5] saying that [HHA-A] had taken money from him. [P5] did tell me about 20 dollars of quarters that [HHA-A] got out of him, but the receipt said 40 dollars was taken out. I did report that to [BOC-A] at that time. [BOC-A] told me that the team that worked there each gave [P5], 5 dollars to get him his money back and told me the problem was solved and there was no need to go any further. We never did figure out where the money went."</p> <p>During an interview on 11/5/19, at 3:17 p.m. Compliance Manager (CM)-A stated, if this would have been reported to me we would have immediately suspended [HH-A], pending an investigation. I would have expected the staff at the time to report this to the state agency (SA) as neglect of care, and then reported to me. CM-A</p>	G 430		

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G 430	<p>Continued From page 21</p> <p>verified patients working with HHA-A at that time were not questioned if they had the missing money and that HHA-A no longer employed with the agency.</p> <p>P5 Neglect of Care P5's PCA service Plan, dated 4/20/18, indicated P5 received PCA services 23 hrs per day. P5's HomecareService Plan dated 4/20/18, indicated P5 received HHA services 3 visits daily.</p> <p>P5's Schedule Verification for April, 2019, indicated there were 10 days where P5 did not receive 23 hours of PCA and HHA services: April 1, 2, 3, 12, 15, 17, 20, 23, 24, and 29th on the days that HHA-C had worked. No coverage provided from 2.5 to 3 hours on the days identified above in the afternoon.</p> <p>Review of a Common Entry Intake Form, dated 5/1/19, identified P5's county case manager (CCM)-A reported that P5 received 24 hour care, and about a month or so ago he had an accident-had wet his pants. The HHA had told P5 she had to leave early and did not put any clothes on him and put him to bed with only a sheet. HHA left at about 3:45 p.m. and the next staff was to arrive at 4:00 p.m., this staff never showed up. P5 stated that FM-C and FM-D showed up and FM-D called the agency and then a staff showed up to help him. P5 further reported that there has been 2 times when he came home from work, no staff was there to meet him and he has a hard time getting the door open to his building.</p> <p>On 11/5/19, at 9:34 a.m. phone interview attempted for FM-D, mailbox was full.</p>	G 430		

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G 430	<p>Continued From page 22</p> <p>During phone interview on 11/5/19, at 9:44 a.m. CCM-A verified she is currently P5's case manager. CCM-A stated, P5 has reported to me on 5/1/19, that about a month ago he was having some staffing issues and that he was left in bed with no pants on it and the staff never showed up. P5 was very embarrassed when his family members ended up showing up to help him. CCM-A verified P5 was unable to get out of bed on his own. CCM-A stated, P5 is in corporate foster care now, give him a call and he will be able to tell you more.</p> <p>During phone interview on 11/5/19, at 10:35 a.m. BOC-(D) stated, I started this position in March, 2019. P5 did not like HHA-C, she set the boundaries and the rules. P5 didn't like that she was by the book and he felt like she was trying to control him. I have never heard of any instance of P5 being left in bed by himself.</p> <p>During phone interview on 11/5/19, at 12:34 p.m. P5 stated, I can't remember who left me in the bed that day. She left me in bed and the next staff never showed up like the one girl said she would. I can't get out of bed myself. I pounded on the wall until someone came to help me. I lived in an apartment at that time. P5 further stated he stopped services in June because the agency didn't have enough people to cover the 24 hour care when I needed it.</p> <p>During phone interview on 11/5/19, at 12:57 p.m. registered nurse (RN)-D stated, she had worked here since February of 2017 and I was P5's RN case manager, that P5 went through a lot of staff and he had his favorites and personality conflicts with others. RN-D stated she was not aware of anyone not providing cares to P5 or being left in</p>	G 430		

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G 430	<p>Continued From page 23 bed alone and that one ever shared that with her.</p> <p>On 11/5/19, at 1:05 p.m. attempted phone interview with FM-C, mailbox was full unable to leave message.</p> <p>On 11/5/19 at 1:07 p.m. attempted phone interview with to FM-D. This surveyor was given the wrong phone number.</p> <p>During interview on 11/5/19, at 1:15 p.m. CM-A stated P5 was a client we had 24 hour services with that he was not aware of any staffing issues with P5, no one ever reported anything to me and was not aware P5 was left in bed alone. CM-A further stated if a family member reported to the Branch office about neglect of care, the branch office should be reporting that to me. This is the first time he have heard of it, and that would have to report this as a VA for neglect of care.</p> <p>During phone interview on 11/5/19, at 2:10 p.m. BOC-A stated, I am no longer the BOC, my employment ended January, 2019. I don't remember ever talking to FM-C about P5 being left in bed by himself.</p> <p>During phone interview on 11/5/19, at 2:30 p.m. Assistant Branch Operation Coordinator (ABOC)-A stated, I do remember that P5 got into an altercation with HHA-C because there was new order to get P5 out of his wheelchair and lay on his side in the bed. He was getting pressure ulcers on his ankles, we were trying to work with him on that. HHA-C put P5 in the bed, she left early maybe by 15 to 20 minutes. HHA-C was reprimanded for leaving P5 in the bed that day. I have no idea why she left him there by himself, she told me P5 said he was fine with it. How I</p>	G 430			

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G 430	<p>Continued From page 24</p> <p>found out P5 was by himself was that his neighbor called me because he was knocking on the wall, he lived in an apartment building, and she lived across the apartment from him so she brought him the phone so he could call me. She called me before even going over there, she called to tell me she could hear knocking on the wall and she wanted to go check on him. I am not sure how she knew to call me. I then called P5's family members because I couldn't have gotten there in enough time. I wanted someone there right away. I was supposed to be there at 4pm, but I ended up getting there around 4:15 pm. He could be left alone in his home for 1 hour a day. My concern is, it was a safety concern because he could not get out of bed on his own, he had no phone, and if there was a fire he would not have been able to get help. He told me he was embarrassed because his family member could not get him out of the bed. He was in the bed with a shirt and his brief, he was not soiled or anything. I did immediately report this to BOC-A, that's when she sat with HHA-C and talked to her about it. I am not sure if it was formal or not. We got approval from P5's case manager for P5 to be left alone for an hour, she had taken him to the doctor, P5 wanted to be able to have personal time. My heart dropped when I got that phone call. P5 told me he was in the bed by himself, because anything could have happened. So I dropped everything and went to go be with him to make sure he was ok. I got there at 4:15 pm. HHA-C left 15-20 minutes early that day.</p> <p>On 11/5/19, at 3:12 p.m. attempted phone interview with HHA-C and an unidentified person stated this was the wrong phone number.</p> <p>On 11/5/19, at 3:17 p.m. CM-A stated, if this</p>	G 430			

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G 430	<p>Continued From page 25</p> <p>would have been reported to me we would have immediately suspended HHA-C, pending a thorough investigation. I would have expected the staff at the time to report this to the SA as a neglect of care, and then report it to me.</p> <p>On 11/5/19, at 3:33 p.m. human resources director (HRD) verified there were no write-ups in HHA-C's personnel file.</p> <p>P6 financial exploitation P6's POC for the certification period from 10/6/19 to 12/4/19, identified P6 was admitted to the agency on 10/11/18, with diagnosis of chronic pain syndrome. The POC also identified P6 was to receive skilled nurse visits 1 per week x 60 days and home health aide (HHA) 0-6 hours per week. P6's HHA care plan dated 11/4/19, identified HHA will assist with bathing, grooming, hygiene, transfers, mobility, meal prep, and light housekeeping.</p> <p>P6's Client Supervisory Note, dated 6/6/19, identified P6 was not satisfied with services, thinks HHA is stealing money from him, made incident report while in home and sent to compliance.</p> <p>Agency, Incident report dated 6/6/19, indicated date incident occurred was on 6/5/19, time it occurred was, "many." Date reported to RN-A was on 6/6/19 at 1:00 p.m. Type of incident reported was property lost/stolen/destroyed and financial exploitation. Incident that occurred: On 6/6/19, P6 reported to me (RN-A), that P6 thought HHA-E was stealing money from him. It started on 5/15/19 when 20 dollars was missing from underneath the salt shaker. P6 had placed 80 dollars there for a privately hired employee, or at</p>	G 430			

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G 430	<p>Continued From page 26</p> <p>least he thought he had, and chalked it up to forgetfulness. The next time HHA-E worked was 5/22/19, again 80 dollars was placed under the salt shaker, and again 20 dollars was missing. On 5/29/19, again 80 dollars was placed underneath the salt shaker in different denominations then 10 dollars was missing, P6 stated, Perhaps I made a mistake, there were many different bills, maybe I counted wrong. Did I really make that mistake? Am I losing it? P6 reported this was about the time he noticed two 100 dollar bills missing, he had them stashed in his wallet that was placed next to the table in his easy chair. P6 stated on 6/1/19, he went to the bank and got 300 dollars and put it in his wallet. On 6/5/19, before HHA-E came into the home, P6 and his spouse counted out 80 dollars and placed it under the salt shaker, then HHA-E came to work. P6 noticed when she was taking the laundry to the kitchen she stopped, put the laundry basket on the table, fiddled with her phone and then continued on into the kitchen. When his privately paid worker showed up they both counted the money, there was 20 dollars missing. When P6 checked his wallet, the 300 dollars he had just gotten was missing and he went nowhere to spend it. Also reported that P6 kept extra cash in a dresser drawer in his bedroom and 40 - 80 dollars was missing from there. Reported to compliance, made incident report, will be pulling HHA-E from the home until further investigation. Action taken to prevent occurrence was client could keep his cash in a more secure location.</p> <p>An additional agency, Incident report was filed by RN-A dated 6/6/19, identifying the date of the incident on 6/5/19, at 10:00 am. Report further indicated the theft was not reported to the police.</p>	G 430		

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G 430	<p>Continued From page 27</p> <p>Review of the Common Entry Point Report Form, dated 6/7/19, identified CM-A reported that P6 reported to RN-A on 6/5/19, that P6 had 20 dollars taken off his table and 200 dollars from his wallet, on 5/29/19, 10 dollars was taken, 5/15/19, 20 dollars was taken and on 6/5/19, 20 dollars was taken off of his table, 300 dollars from his wallet and 40 to 80 dollars off of his dresser. HHA-E was the alleged perpetrator.</p> <p>An Agency Internal Investigation Report dated 7/3/19, identified an incident occurred 6/6/19. Date report came into compliance was 6/6/19. Dates of investigation were 6/6/19 to 7/3/19. P6 was interviewed. HHA-E was interviewed and verified she worked for P6 on Mondays, Wednesdays and Fridays for a month. HHA-E stated, "I took the 20 dollars the one time, but no other time. My brain may not have thought about it. I saw it and a bad light went on. I was on E and needed gas." Recommendations of the compliance officer regarding the results of the investigation: after the interview with HHA-B, compliance recommends termination of employment. This recommendation will be brought to the director of human resources.</p> <p>During phone interview on 11/1/19, at 2:19 p.m. P6 stated, back in May, I had a home health aide come every Wednesday to help me, I would put out money for my housekeeper and paid the housekeeper \$80 every week. So I would set the money out on the table underneath the salt shaker. Well the money I left out for the housekeeper kept coming up short. On 5/8/19, I was missing 20 dollars off the table and 200 dollars from my wallet, On 5/15/19, 20 dollars was taken, on 5/29/19, 30 dollars was taken, on</p>	G 430		

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G 430	<p>Continued From page 28</p> <p>6/5/19, 20 dollars was taken off the table, 300 dollars out of my wallet, and 40- 80 dollars was taken off of my dresser. "I thought I was going senile." The last 2 weeks that HHA-E was here, my wife and I counted the money and on both instances we were 20-30 dollars a week short. When I suspected something was going on, I had my wallet next to me in the living room and I always keep two 100.00 dollar bills in my wallet, because sometimes I wouldn't leave my house for 3 -4 weeks at a time, then I would need to pay someone for something and then my money would be gone. I reported this to the company, and they never did get back to me. The nurse that comes here once a week, (RN-A), she is the one who told me that HHA-E admitted that she took my money all those times and they had to let her go. It made me feel better that she admitted it, I really thought I was losing it. My wife and I would count the money together because we both thought we were losing it. The agency never reimbursed me.</p> <p>During phone interview on 11/4/19, at 2:11 p.m. RN-A stated, "[P6] did report to me some missing money back in June. The homemaker was [HHA-E]. The first time [P6] told me he thought this happened, but could have made a mistake so let's just forget about it. He paid someone cash that was left on the table for the person to pick up. Whenever HHA-E came again, he counted the money with his wife. The guy that was getting paid, said he was missing 20 dollars. [P6] stated he just did not want her in the house anymore, so we took her out of the house at that point." RN-A stated she probably wrote in on a progress note, probably did not report this, he did not want me to. He said that 20 dollars would not make him or break him. He did mention that he was missing</p>	G 430			

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G 430	<p>Continued From page 29</p> <p>200 dollars from his wallet on a couple occasions. What I got from him, he had so many people coming in and out of the house that he wasn't sure who did it. RN-A stated she reported incident to BOC-B and did not know the company policy on reimbursement and that P6 never mentioned the money or HHA-E again.</p> <p>During interview on 11/4/19, at 2:45 p.m. BOC-B stated P6 always reported to RN-A and then she would report to me. BOC-A stated she was made aware of P6's missing money once compliance was doing an investigation, was informed by compliance that he needed to reach out and let HHA-E know she was suspended to make sure she wasn't working with any clients. She was suspended for a week. After investigation they emailed and notified me to fill out and EOE, an end of employment, then it goes into her e-chart. HHA-E employment was ended on 7/1/19, at 3:45 pm, she was terminated effective immediately due to client incident report involving stealing of client money. At the end of investigation they found her to be guilty of stealing the money. Her last shift was 6/6/19. BOC-A stated did not get back to P6 about the missing money, that would be CM-A's job, she should follow up with client. BOC-A further stated our policy is we can ask the client if they want to press charges, we would file a report with police department was not sure but thought a police report was made.</p> <p>During interview on 11/4/19, at 3:28 p.m. CM-A stated, I was first notified of P6's missing money on 6/6/19. I reported this to MAARC on 6/7/19, at 4:16 p.m. Our policy is that everyone is a mandated reporter and they are to fill out the incident report and then report it to me and I will report it to the state. My suggestion to [P6] was</p>	G 430			

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G 430	<p>Continued From page 30</p> <p>to call law enforcement and [P6] told me, I am not sure I am inclined to do that. That requires a lot of time to go in and out of his house and he was not ready to do that. [P6] was real leery of [HHA-E], there was no definitive way he could prove it. He didn't feel this worker should be going into any other person's house. We suspended [HHA-E] on 6/7/19, at 4:51 p.m., indefinitely, she was termed on 7/1/19 at 3:45 pm. I don't recall if I ever got a chance to let [P6] know what the results of the investigation were. CM-A verified HHA-E took care of other clients during that time frame, and CM-A verified he did not check with the other clients to see if they had any concerns with missing money. At 4:21 p.m. CM-A stated, we do not have a specific policy on resolution to financial exploitation. I did not report this to the police department. CM-A stated, the policy states if an incident is reported to MAARC and there is reason to believe a crime was committed, we should be immediately reporting this to law enforcement.</p> <p>During phone interview on 11/5/19, at 12:44 p.m. HHA-E stated, she did work with P6 and was aware of the reports of missing money that P6 was blaming her for taking a couple hundred dollars. HHA-E stated she did not take a couple hundred but had taken a twenty on his table and had admitted to taking that. HHA-E further stated the company is not good at communication, that CM-A had told me he had to report this. He said someone would be calling me at the end of the day. "They never called me again, so I assumed I was fired. I never did pay [P6] back. I didn't want to get in trouble for texting him, because [CM-A] told me I was not to have any contact with him. [P6] did end up texting me this big long paragraph and it made</p>	G 430			

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G 430	<p>Continued From page 31 me feel bad, so I wanted to pay him back."</p> <p>P7's neglect of care P7's POC for the certification period from 4/3/19 to 4/1/20, identified P7 was admitted to the agency on 4/3/18, with diagnosis of type 2 diabetes mellitus, chronic obstructive pulmonary disease (COPD), and major depressive disorder. The POC also identified P7 was to receive personal care attendants (PCA) 0.6 to 3 hours of service every day x 12 months.</p> <p>P7's undated PCA care plan, identified PCA would assist with bathing, dressing, undressing, grooming, mobility, transfers, mood/behavior, light housekeeping, meals and medications.</p> <p>P7's Supervisory Note dated 7/16/19, indicated P7 was not satisfied with her services, HHA-D is chronically late and argues with client. "[P7] doesn't want to change workers, [HHA-D] threatened to leave the client. Worker argued with client."</p> <p>Review of Employee Coaching and Counseling Notice dated 7/17/19, identified a verbal warning to HHA-D and indicated a concern: clients have been concerned about HHA-D taking her maternity leave and want to know when her last day will be. This has been brought to my attention more than once and RN-E has also talked with HHA-D and HHA-D stated that she doesn't know why her clients are stating this. She claims that she has not said anything to them to make them think that. P7 reported to LPN-B that HHA-D refused to do things her way and said, "If you don't like the way I am doing things, I will leave and not come back because I am taking maternity leave." This concern violates the</p>	G 430		

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G 430	<p>Continued From page 32</p> <p>following company policy: be involved in verbal argument in front of customers, insubordination-refusal to comply with instructions of a supervisor or other deliberate and inexcusable refusal to obey a reasonable order which relates to an employee's job function. Correction expected: I expect this rumor to stop. I expect clients to feel secure and satisfied with services and not have the concern on their mind about losing their aide when that is not true. I expect HHA-D to follow proper procedures and care plan when providing cares. If HHA-D doesn't agree with client about a certain task it needs to be brought to my attention or another staff member.</p> <p>Review of a Common Entry Point Intake Form dated 7/25/19, indicated P7 and her social worker (SW)-A met and P7 stated her PCA was emotionally abusing her. P7 was crying and couldn't understand why someone would do this to her. P7 reported she attempted to get a new PCA, but the agency could not provide this. HHA-D would intentionally ignore P7 when she would ask for physical assistance with tasks identified in P7's POC. P7 reported she would yell at HHA-D and would be ignored and HHA-D would tell P7 that she couldn't hear her even when in the next room, then she would smirk at her. HHA-D told P7 that she was pregnant and due any day so she could not complete tasks that would require bending over and refused to perform tasks identified in P7's POC. P7 then stated she called the agency to find out when HHA-D would be on maternity leave and they reported to her that HHA-D was not pregnant and is able to perform the tasks. P7 would communicate her needs to HHA-D and she would later tell P7 she did not say that. These recurring</p>	G 430			

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G 430	<p>Continued From page 33</p> <p>incidents made P7 feel like she was losing her mind. HHA-D later retracted statements per P7. P7 reported these incidents have caused her emotional stress and mental health instability which has resulted in a lack of trust for other providers to come into her home to assist her with tasks she needs.</p> <p>During a phone interview on 11/1/19, at 3:36 p.m. P7 stated, HHA-D started working with her during this last midwinter, that she had a hard time back then, that her car had been broken 3 times, wasn't getting much company, and HHA-D had her thinking she was going crazy. P7 stated one time, she told HHA-D not to do the laundry because there wasn't enough of it to do and that she wanted her to wait. P-7 stated HHA-D she put the basket of laundry above her head, where she couldn't reach it, that she told her not to, yet P7 ran and put it all in one load in the washing machine. P7 further stated she didn't want the colors and the whites mixed together. P7 also stated sometimes HHA-D would tell me she couldn't do anything that required bending down because she was pregnant and she would tell me, "I don't want to break the baby's neck." She had made my head running. P7 furhter stated sometimes she would pretend to not hear me when I would ask her something and pretend she was deaf, and then she would turn and smirk at me. When the agency finally realized what she was doing to me, they removed her from my home. However, HHA-D continued to work with me 3 or 4 more times after this had been reported because there was no one else to work with me. P7 also stated she just kept my mouth shut on those days and cried so much, "she had me thinking I was losing my mind". P7 went on to state, when HHA-D was working with her, she</p>	G 430			

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G 430	<p>Continued From page 34</p> <p>was begged her not to say anything on those days she was here, but it was too late, she had already told on her. P7 stated HHA-D doesn't work for me anymore and if she still did, she probably would be crazy .</p> <p>During phone interview on 11/4/19, at 9:49 a.m. registered nurse (RN)-E verified P7 received PCA services and stated, she opened her case, and she is a current client. A while back there was a PCA that P7 wasn't happy with. She did not like the one gal, it was HHA-D. HHA-D kept telling her clients she was pregnant and she would be leaving soon and that they would have to find someone else.</p> <p>During a phone interview on 11/4/19, at 10:03 a.m. LPN-B verified she did the supervisory visits for P7 back in July, 2019. They were having some issues, so RN-E had to take over. P7 complained about HHA-D, she said she was a good worker but she liked doing things her own way. LPN-B stated P7 did report to her that HHA-D told her she was pregnant. LPN-B verified on 7/16/19, a supervisory visit was completed and P7 did tell her several times that HHA-D liked to do things her way, then P7 would suggest a different way and HHA-D would tell her she was pregnant and wouldn't be working with her for very long anyways. LPN-B further stated she should have reported this to my branch office coordinator, could not remember if she did or not.</p> <p>During phone interview on 11/4/19, at 10:55 a.m. BOC-C stated, she has worked here since 2014, that she did talk to P7 the first or second week in July and that P7's SW-A, had called her with concerns. She also mentioned that HHA-D was refusing to help P7 with some things because of</p>	G 430			

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G 430	<p>Continued From page 35</p> <p>her pregnancy like bending over, lifting, and moving furniture around. BOC-C stated she then talked with P7 and told her I told her we could find her someone else and that P7 stated said she would like that. BOC-C further stated that during a meet and greet for a new staff that would be starting with P7, P7 stated how horrible she felt about HHA-D, that she had felt very intimidated, if she asked HHA-D to do something, she would tell her, too bad I am not going to do it.</p> <p>During subsequent phone interview on 11/5/19, at 8:30 a.m. P7 stated, "[HHA-D] was supposed to help me with minimal personal cares, and house work. I couldn't use her as a PCA because she made her too uncomfortable. She reported that half the time she had to run around with one sock on because she couldn't get it on. [P7] also stated she was very worried about who would help her, and stated [HHA-D] was a good housekeeper without the mental mind games." P7 stated HHA-D would run away from her with her laundry basket and shove 3 loads in the washing machine. P7 futher stated she would cry and HHA-D would half smile at her.</p> <p>During interview on 11/5/19 at 1:32 p.m., CM-A verified P7 is a current client receiving services, 2 hours 3 times a week. It would be in your job description to bend over and lift things to provide care for P7. CM-A indicated that no one ever reported that to her. That she would expect with neglect of care or any other abuse, maltreatment for the BOC's to be reporting this to the State Agency (SA). They are mandated reporters. Then they would report to me. Then you immediately remove the alleged perpetrator (suspend) pending the outcome of the investigation. CM-A stated HHA-D currently</p>	G 430			

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G 430	Continued From page 36 works with 4 other clients, and that CM-A was going to look into this immediately. The agency's Service Policies C.22 Vulnerable Clients, updated 6/28/18, indicated Purpose Adults: 1. To protect individuals who, because of physical or mental disability or dependence on home health services, are particularly vulnerable to abuse or neglect. 2. To ensure a safe living environment for vulnerable individuals who are receiving services. 3. To identify within the client's home all potential areas that might contribute to vulnerability and include corrective measures in the care plan. 4. To provide protection to individuals reporting abuse or neglect within the parameters of the law. 5. To require the reporting of suspected maltreatment of vulnerable adults to the statewide common entry point and to provide the completed investigation information to them when requested. Policy: It is the policy of International Quality Homecare (IQH) to protect clients who are vulnerable to neglect, abuse, or maltreatment due to physical or mental disability. All IQH staff, including volunteers and temporary workers are mandated reporters. A mandated reporter is anyone who comes in contact with a vulnerable adult or child. All clients receiving care (with the exception of homemaker only) are considered to be vulnerable adults. Internal Reporting Procedure 10. If an employee is the suspected abuser, the employee is removed from the home and will be removed from any other scheduled home care services during the investigation. The employee will be informed not to have any contact with the vulnerable adult or minor to prevent retaliatory issues from occurring.	G 430			
G 488	Immediate reporting of abuse by all staff CFR(s): 484.50(e)(2)	G 488			

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G 488	<p>Continued From page 37</p> <p>Any HHA staff (whether employed directly or under arrangements) in the normal course of providing services to patients, who identifies, notices, or recognizes incidences or circumstances of mistreatment, neglect, verbal, mental, sexual, and/or physical abuse, including injuries of unknown source, or misappropriation of patient property, must report these findings immediately to the HHA and other appropriate authorities in accordance with state law. This ELEMENT is not met as evidenced by: Based on interview and document review, the agency staff failed to report immediately to the State Agency (SA) allegations of verbal abuse, neglect of care, and financial exploitation for 5 of 7 patients (P1, P2, P4, P5, P7) reviewed for abuse reporting. This had the potential to affect all patients served by this agency.</p> <p>Findings include:</p> <p>P1's Plans of Care (POC) dated 7/16- 9/13/19 and 9/14- 11/2/19, indicated P1's start of care (SOC) was 5/22/18. P1's diagnoses included venous insufficiency, lymphedema and atrial fibrillation. The POC also indicated P1 was to receive skilled nursing visits 0-3 visits per week for 60 days for wound care, education about medication use and nursing staff to clean, dress, wrap lower extremities, monitor lower legs for any open areas. P1's POC also indicated P1 was oriented in relation to mental status.</p> <p>Review of a Common Entry Point Intake Form dated 10/14/19, indicated P1 had reported to the compliance department of the agency that registered nurse (RN)-A threatened to slap him,</p>	G 488			

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G 488	<p>Continued From page 38</p> <p>and he feared that she was going to. The report indicated P1 had reported RN-A had visited him on 8/16/19, after he had returned home from the hospital on 8/12/19. P1 stated he was supposed to go to rehab (rehabilitation), but had explained to RN-A he was not going to go because he had too much work to do around the house. P1 reported at that time, RN-A stated that someone should smack him across the face for turning that down, and P1 reported he felt RN-A was actually going to slap him. Further, the report indicated RN-A had been removed from P1's home and would no longer provide cares for P1.</p> <p>The agency's Internal Investigation Report, identified the following through interviews the agency had conducted: On 10/14/19, the compliance manager (CM)-A interviewed P1. P1 stated to CM-A, "The incident or close encounter was because I was supposed to do rehab. I mentioned that I couldn't go and she [RN-A] said to me, 'you ought to have your face slapped' for turning that down." P1 reported, "Her [RN-A] face was red, eyes enlarged, and I could smell her breath. I thought she was going to slap me. She is argumentative and once had to leave me to sit in her car for about ten minutes, I think it was to calm down. Every time she comes here, she raises her voice and is demanding." P1 reported the incident occurred on Friday August 16 (2019). P1 had further stated he felt threatened and stated, "Any minute I thought her hand was going to hit my face. I'm not sure why she didn't do it." According to the report CM-A asked if there were any additional incidents to where he felt threatened and P1 stated, "She cannot take no for an answer. She would get mad and argumentative. She would talk down to me and I don't like to be talked down to. We would</p>	G 488		

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G 488	<p>Continued From page 39</p> <p>argue so much that I would tell her to listen, get my legs done here and when you are done, get the hell out of here."</p> <p>The report indicated on 10/14/19, CM-A had interviewed RN-B. RN-B had reported, "A while ago [RN-A] told me she had gotten into an argument with [P1]."</p> <p>The documents indicated on 10/17/19, CM-A had interviewed LPN-A. The documents indicated LPN-A had reported P1 told her RN-A had said she [RN-A] had half the audacity to smack him across the face.</p> <p>During interview on 10/29/19 at 1:07 p.m., P1 stated the incident with RN-A had occurred on Friday 8/16/19, when RN-A came to change the dressings for wounds on his legs. P1 stated, "The hospital wanted me to go to rehab, but I told her I couldn't go. She got real perturbed saying, 'You mean to tell me you turned that down?' When I told her 'Yeah I have too much to do' she got mad and said, 'You ought a have your face slapped', she was close to me, her face was real red, I could smell her breath and her eyes were as big as quarters. She Looked angry. I thought she was going to slap me, but she didn't. I think she had intent. Another time she got mad, walked out of the house and sat in her car fifteen minutes and I did not know if she was going to change the dressings on my legs. About a month or two ago she went into my bedroom, went through my medical supplies and tried to consolidate them. I had it in order so I told her to get the hell out of there, I have everything in order. I told her, 'Change the dressings since that is what you are here for.' She never asked permission to go into the bedroom. About every time she came out</p>	G 488		

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G 488	<p>Continued From page 40</p> <p>here, her and I would get in an argument. She was very negative, not very professional in actions or words. Most of the time she would start arguing about anything I would say. It got to be a pain in the neck. At first I did not report it to the home health agency, as I did not know what she was going to do. About August 27th, I mentioned it to the nurse that comes on Tuesdays. I told her that RN-A threatened to slap me and I asked for a different nurse to come on Fridays. She said, 'You should report this.' I called someone at the [agency] and reported it to them because the nurse on Tuesday told me to."</p> <p>An agency email dated Friday 10/11/19, at 4:35 p.m. sent from RN-B to the administrator, included RN-B had informed the administrator there were separate vulnerable adult and child situations related to RN-A. The first being P1. "She threatened to slap him and he actually feared she was going to. He would like to make a report with his details." The administrator had forwarded the email to CM-A on Friday 10/11/19, at 9:12 p.m.</p> <p>P2's current POC dated 10/14-12/12/19, indicated P2's SOC was 12/18/18. P2's diagnoses included hypertension, type two diabetes, hypothyroidism and a very low level of personal hygiene. The POC also indicated P2 was to receive skilled nursing visits 0-1 visits per week for 60 days for management of medications.</p> <p>An agency email dated Friday 10/11/19 at 4:35 p.m., sent from RN-B to the administrator, included RN-B reporting there were separate vulnerable adult and child situations related to RN-A. The other being P2, who RN-A yelled at</p>	G 488		
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G 488	<p>Continued From page 41</p> <p>and told him how disgusting he lives. The administrator had forwarded the email to CM-A on Friday 10/11/19, at 9:12 p.m.</p> <p>Review of a Common Entry Point Intake Form dated 10/14/19, indicated it was reported to the compliance department of the agency that P2 had been yelled at by RN-A about how disgusting he lives. The report indicated P2 stated about two to three months ago RN-A had been abusive to him, not physically but verbally. P2 stated he did recall what was said but did not feel comfortable speaking to me (CM-A). P2 stated he believed the problem had been resolved because RN-A had not been coming there anymore.</p> <p>The agency Internal Investigation Report identified the following through interviews the agency had conducted: On 10/14/19, CM-A had interviewed P2. P2 was asked to explain the incident that occurred involving him and RN-A. P2 stated, "Well I am not really sure, it may be a personality conflict. I have been here 9 years. I have had a lot of nurses. [RN-A] has been abusive to me, not physically, just verbally. After a while, I didn't think I should have to go through this, so I called the Ombudsman." When asked what RN-A had said to him, P2 stated, "Yeah, I remember. I am not real comfortable sharing with you what she said. I just don't think I should be treated like that."</p> <p>On 10/14/19, CM-A had interviewed RN-B. RN-B reported she had overheard RN-A speak of how disgusting P2 lives. RN-B stated she had heard from LPN-A that RN-A had yelled at P2.</p> <p>On 10/15/19, CM-A had interviewed RN-A. CM-A had asked RN-A about P2. The documentation</p>	G 488			

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G 488	<p>Continued From page 42</p> <p>indicated RN-A stated, "I have seen [P2] last week. His room is pungent. I get stopped by residents that talk about how bad he smells. He has been receiving eviction notices. He is a slob." CM-A asked RN-A if she had mentioned that to P2</p> <p>'in so many words,' RN-A said, "Yes I have. He throws his food and his incontinent pads not in the trash, but on the floor. His hair is knotted. His beard and clothes have dry milk and frosting. All of the homemakers have been told that he would shower another day. His floor is so sticky that your shoes stick to the floor. He called his social worker saying that he did not want me anymore."</p> <p>On 10/17/19, CM-A had interviewed LPN-A. LPN-A stated, "He [P2] says that she [RN-A] yells at him and calls him disgusting. Says she [RN-A] is rude ...he uses higher words I don't understand. Does not treat him with respect or dignity."</p> <p>During interview on 11/1/19, at 1:27 p.m. P2 stated, "I reported this a month or two ago, it had been a while I was being verbally abused with her language. I reported to the Ombudsman and he talked to someone at the [agency]. The Ombudsman talked to someone at [agency] and they stopped sending [RN-A]. [RN-A] came one time a week to set up meds, order meds and pick up meds. She was verbally abusive about things. She talked about the condition of my apartment, personal condition and I told her I was taking steps to correct this. The basic thing she said was there is an aroma in your apartment. She harped on that a lot. I have a urinary incontinence problem and I wear undergarments to help. It's a medical problem and it's a real frustrating thing for me. It is terrible to be criticized by someone</p>	G 488			

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G 488	<p>Continued From page 43</p> <p>who is a health care worker. I have lived here for nine years and had a lot of nurses, and never had someone treated me like that. She should be aware of personal feelings I have and medical problems. The nurses told me before 'don't take a shower unless someone is in the apartment', so I waited each week for the housekeeper to be there when I took shower in case something happened. [RN-A] was complaining I was not taking care of my personal hygiene well enough, I have a body odor." "I said well I am taking a shower two to three times a week when the housekeeper was here. I felt I was being abused verbally by what she said. I thought the things she said were not necessary."</p> <p>During interview on 11/1/19, at 2:57 p.m., LPN-A stated before she started providing cares for P2, RN-A had told her, "How disgusting he is. That he pisses all over himself and the furniture. There is food everywhere. He is an extremely intelligent man but does not have any hygiene." LPN-A stated RN-A had stated, "We are not allowed to carry anything into the apartment with us. You go in there, you grab his pill thing and you walk out. You set up medication, take it back to him, he will look at them close up and put them away, he will sign paper and leave." "She said not to let him even use my pen." LPN-A stated RN-A had gone to P2's apartment on 10/8/19, to provide service for P2, as she was not able to work and had to take the day off." LPN-A stated, she had called P2 on 10/10/19, to see how he was doing and to make sure the visit went ok. LPN-A stated, "[RN-A] and [P2] had verbal arguments and he does not feel he is treated properly. She belittles him and does not treat him with any dignity or respect."</p>	G 488		
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G 488	<p>Continued From page 44</p> <p>The agency Schedule Verification for P2, identified on Wednesday 10/9/19, RN-A had provided services for P2. Start time of 4:54 p.m. and end time of 5:45 p.m.</p> <p>During interview on 11/5/19, at 1:24 p.m. the administrator verified the date and time of the email regarding P1 and P2. The administrator stated she would not be surprised if the incidents did not get reported to the State Agency until Monday, "I don't think anybody is checking emails over the weekend. Everyone is a mandated reporter and I would have expected [RN-B] to have filled out an incident report and report the incidents to the State Agency." The administrator stated she was not aware what the recommendations of the investigations for P1 and P2 were in regards to RN-A.</p> <p>P4's plan of care (POC) dated 7/9- 9/6/19, indicated P4's start of care was 5/15/18. P4's diagnoses included diabetes and atrial fibrillation. The POC also indicated P4 was to receive skilled nursing visits 0-1 visits every week for 60 days for medication set up and assessment, and home health aide (HHA) 0-2 visits each week for 60 days to assist client with bathing, dressing upper body, skin care and hair care.</p> <p>An agency Incident Report dated 8/1/19 at 11:00 a.m., indicated P4 had reported that her care giver was stealing her personal items, such as a picture that was missing. The Incident Report indicated P4 was sure there were other items in addition to the missing picture, but she could not think of them off the top of her head.</p> <p>Review of a Common Entry Point Intake Form identified the incident P4's report of missing</p>	G 488		

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G 488	<p>Continued From page 45</p> <p>picture from 8/1/19 had not been reported to the State Agency until 8/6/19.</p> <p>During interview on 11/5/19, at 9:47 a.m., CM-A confirmed the incident had not been reported to the SA, until 8/6/19 and verified it should have been reported immediately.</p> <p>P5 Neglect of Care P5's PCA service Plan, dated 4/20/18, indicated P5 received PCA services 23 hrs per day. P5's HomecareService Plan dated 4/20/18, indicated P5 received HHA services 3 visits daily.</p> <p>P5's Schedule Verification for April, 2019, indicated there were 10 days where P5 did not receive 23 hours of PCA and HHA services: April 1, 2, 3, 12, 15, 17, 20, 23, 24, and 29th on the days that HHA-C had worked. No coverage provided from 2.5 to 3 hours on the days identified above in the afternoon.</p> <p>Review of a Common Entry Intake Form, dated 5/1/19, identified P5's county case manager (CCM)-A reported that P5 received 24 hour care, and about a month or so ago he had an accident-had wet his pants. The HHA had told P5 she had to leave early and did not put any clothes on him and put him to bed with only a sheet. HHA left at about 3:45 p.m. and the next staff was to arrive at 4:00 p.m., this staff never showed up. P5 stated that FM-C and FM-D showed up and FM-D called the agency and then a staff showed up to help him. P5 further reported that there has been 2 times when he came home from work, no staff was there to meet him and he has a hard time getting the door open to his building.</p>	G 488		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248078	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/05/2019
NAME OF PROVIDER OR SUPPLIER INTERNATIONAL QUALITY HOMECARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3261 19TH ST NORTHWEST ROCHESTER, MN 55901		
(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 488	<p>Continued From page 46</p> <p>On 11/5/19, at 9:34 a.m. phone interview attempted for FM-D, mailbox was full.</p> <p>During phone interview on 11/5/19, at 9:44 a.m. CCM-A verified she is currently P5's case manager. CCM-A stated, P5 has reported to me on 5/1/19, that about a month ago he was having some staffing issues and that he was left in bed with no pants on it and the staff never showed up. P5 was very embarrassed when his family members ended up showing up to help him. CCM-A verified P5 was unable to get out of bed on his own. CCM-A stated, P5 is in corporate foster care now, give him a call and he will be able to tell you more.</p> <p>During phone interview on 11/5/19, at 10:35 a.m. BOC-(D) stated, I started this position in March, 2019. P5 did not like HHA-C, she set the boundaries and the rules. P5 didn't like that she was by the book and he felt like she was trying to control him. I have never heard of any instance of P5 being left in bed by himself.</p> <p>During phone interview on 11/5/19, at 12:34 p.m. P5 stated, I can't remember who left me in the bed that day. She left me in bed and the next staff never showed up like the one girl said she would. I can't get out of bed myself. I pounded on the wall until someone came to help me. I lived in an apartment at that time. P5 further stated he stopped services in June because the agency didn't have enough people to cover the 24 hour care when I needed it.</p> <p>During phone interview on 11/5/19, at 12:57 p.m. registered nurse (RN)-D stated, she had worked here since February of 2017 and was P5's RN</p>	G 488		

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G 488	<p>Continued From page 47</p> <p>case manager, that P5 went through a lot of staff and he had his favorites and personality conflicts with others. RN-D stated she was not aware of anyone not providing cares to P5 or being left in bed alone and that one ever shared that with her.</p> <p>On 11/5/19, at 1:05 p.m. attempted phone interview with FM-C, mailbox was full unable to leave message.</p> <p>On 11/5/19 at 1:07 p.m. attempted phone interview with to FM-D. This surveyor was given the wrong phone number.</p> <p>During interview on 11/5/19, at 1:15 p.m. CM-A stated P5 was a client we had 24 hour services with that he was not aware of any staffing issues with P5, no one ever reported anything to me and was not aware P5 was left in bed alone. CM-A further stated if a family member reported to the Branch office about neglect of care, the branch office should be reporting that to me. This is the first time he have heard of it, and that would have to report this as a VA for neglect of care.</p> <p>During phone interview on 11/5/19, at 2:10 p.m. BOC-A stated, I am no longer the BOC, my employment ended January, 2019. I don't remember ever talking to FM-C about P5 being left in bed by himself.</p> <p>During phone interview on 11/5/19, at 2:30 p.m. Assistant Branch Operation Coordinator (ABOC)-A stated, I do remember that P5 got into an altercation with HHA-C because there was new order to get P5 out of his wheelchair and lay on his side in the bed. He was getting pressure ulcers on his ankles, we were trying to work with him on that. HHA-C put P5 in the bed, she left</p>	G 488		

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G 488	Continued From page 48 early maybe by 15 to 20 minutes. HHA-C was reprimanded for leaving P5 in the bed that day. I have no idea why she left him there by himself, she told me P5 said he was fine with it. How I found out P5 was by himself was that his neighbor called me because he was knocking on the wall, he lived in an apartment building, and she lived across the apartment from him so she brought him the phone so he could call me. She called me before even going over there, she called to tell me she could hear knocking on the wall and she wanted to go check on him. I am not sure how she knew to call me. I then called P5's family members because I couldn't have gotten there in enough time. I wanted someone there right away. I was supposed to be there at 4pm, but I ended up getting there around 4:15 pm. He could be left alone in his home for 1 hour a day. My concern is, it was a safety concern because he could not get out of bed on his own, he had no phone, and if there was a fire he would not have been able to get help. He told me he was embarrassed because his family member could not get him out of the bed. He was in the bed with a shirt and his brief, he was not soiled or anything. I did immediately report this to BOC-A, that's when she sat with HHA-C and talked to her about it. I am not sure if it was formal or not. We got approval from P5's case manager for P5 to be left alone for an hour, she had taken him to the doctor, P5 wanted to be able to have personal time. My heart dropped when I got that phone call. P5 told me he was in the bed by himself, because anything could have happened. So I dropped everything and went to go be with him to make sure he was ok. I got there at 4:15 pm. HHA-C left 15-20 minutes early that day. On 11/5/19, at 3:12 p.m. attempted phone	G 488			

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G 488	<p>Continued From page 49</p> <p>interview with HHA-C and an unidentified person stated this was the wrong phone number.</p> <p>On 11/5/19, at 3:17 p.m. CM-A stated, if this would have been reported to me we would have immediately suspended HHA-C, pending a thorough investigation. I would have expected the staff at the time to report this to the SA as a neglect of care, and then report it to me.</p> <p>On 11/5/19, at 3:33 p.m. human resources director (HRD) verified there were no write-ups in HHA-C's personnel file.</p> <p>P7's neglect of care P7's POC for the certification period from 4/3/19 to 4/1/20, identified P7 was admitted to the agency on 4/3/18, with diagnosis of type 2 diabetes mellitus, chronic obstructive pulmonary disease (COPD), and major depressive disorder. The POC also identified P7 was to receive personal care attendants (PCA) 0.6 to 3 hours of service every day x 12 months.</p> <p>P7's undated PCA care plan, identified PCA would assist with bathing, dressing, undressing, grooming, mobility, transfers, mood/behavior, light housekeeping, meals and medications.</p> <p>P7's Supervisory Note dated 7/16/19, indicated P7 was not satisfied with her services, HHA-D is chronically late and argues with client. "[P7] doesn't want to change workers, [HHA-D] threatened to leave the client. Worker argued with client."</p> <p>Review of Employee Coaching and Counseling Notice dated 7/17/19, identified a verbal warning</p>	G 488			

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G 488	<p>Continued From page 50</p> <p>to HHA-D and indicated a concern: clients have been concerned about HHA-D taking her maternity leave and want to know when her last day will be. This has been brought to my attention more than once and RN-E has also talked with HHA-D and HHA-D stated that she doesn't know why her clients are stating this. She claims that she has not said anything to them to make them think that. P7 reported to LPN-B that HHA-D refused to do things her way and said, "If you don't like the way I am doing things, I will leave and not come back because I am taking maternity leave." This concern violates the following company policy: be involved in verbal argument in front of customers, insubordination-refusal to comply with instructions of a supervisor or other deliberate and inexcusable refusal to obey a reasonable order which relates to an employee's job function. Correction expected: I expect this rumor to stop. I expect clients to feel secure and satisfied with services and not have the concern on their mind about losing their aide when that is not true. I expect HHA-D to follow proper procedures and care plan when providing cares. If HHA-D doesn't agree with client about a certain task it needs to be brought to my attention or another staff member.</p> <p>Review of a Common Entry Point Intake Form dated 7/25/19, indicated P7 and her social worker (SW)-A met and P7 stated her PCA was emotionally abusing her. P7 was crying and couldn't understand why someone would do this to her. P7 reported she attempted to get a new PCA, but the agency could not provide this. HHA-D would intentionally ignore P7 when she would ask for physical assistance with tasks identified in P7's POC. P7 reported she would</p>	G 488		

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G 488	<p>Continued From page 51</p> <p>yell at HHA-D and would be ignored and HHA-D would tell P7 that she couldn't hear her even when in the next room, then she would smirk at her. HHA-D told P7 that she was pregnant and due any day so she could not complete tasks that would require bending over and refused to perform tasks identified in P7's POC. P7 then stated she called the agency to find out when HHA-D would be on maternity leave and they reported to her that HHA-D was not pregnant and is able to perform the tasks. P7 would communicate her needs to HHA-D and she would later tell P7 she did not say that. These recurring incidents made P7 feel like she was losing her mind. HHA-D later retracted statements per P7. P7 reported these incidents have caused her emotional stress and mental health instability which has resulted in a lack of trust for other providers to come into her home to assist her with tasks she needs.</p> <p>During a phone interview on 11/1/19, at 3:36 p.m. P7 stated, HHA-D started working with her during this last midwinter, that she had a hard time back then, that her car had been broken 3 times, wasn't getting much company, and HHA-D had her thinking she was going crazy. P7 stated one time, she told HHA-D not to do the laundry because there wasn't enough of it to do and that she wanted her to wait. P-7 stated HHA-D she put the basket of laundry above her head, where she couldn't reach it, that she told her not to, yet P7 ran and put it all in one load in the washing machine. P7 further stated she didn't want the colors and the whites mixed together. P7 also stated sometimes HHA-D would tell me she couldn't do anything that required bending down because she was pregnant and she would tell me, "I don't want to break the baby's neck." She</p>	G 488			

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G 488	<p>Continued From page 52</p> <p>had made my head running. P7 furhter stated sometimes she would pretend to not hear me when I would ask her something and pretend she was deaf, and then she would turn and smirk at me. When the agency finally realized what she was doing to me, they removed her from my home. However, HHA-D continued to work with me 3 or 4 more times after this had been reported because there was no one else to work with me. P7 also stated she just kept my mouth shut on those days and cried so much, "she had me thinking I was losing my mind". P7 went on to state, when HHA-D was working with her, she was begged her not to say anything on those days she was here, but it was too late, she had already told on her. P7 stated HHA-D doesn't work for me anymore and if she still did, she probably would be crazy .</p> <p>During phone interview on 11/4/19, at 9:49 a.m. registered nurse (RN)-E verified P7 received PCA services and stated, she opened her case, and she is a current client. A while back there was a PCA that P7 wasn't happy with. She did not like the one gal, it was HHA-D. HHA-D kept telling her clients she was pregnant and she would be leaving soon and that they would have to find someone else.</p> <p>During a phone interview on 11/4/19, at 10:03 a.m. LPN-B verified she did the supervisory visits for P7 back in July, 2019. They were having some issues, so RN-E had to take over. P7 complained about HHA-D, she said she was a good worker but she liked doing things her own way. LPN-B stated P7 did report to her that HHA-D told her she was pregnant. LPN-B verified on 7/16/19, a supervisory visit was completed and P7 did tell her several times that</p>	G 488			

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G 488	<p>Continued From page 53</p> <p>HHA-D liked to do things her way, then P7 would suggest a different way and HHA-D would tell her she was pregnant and wouldn't be working with her for very long anyways. LPN-B further stated she should have reported this to my branch office coordinator, could not remember if she did or not.</p> <p>During phone interview on 11/4/19, at 10:55 a.m. BOC-C stated, she has worked here since 2014, that she did talk to P7 the first or second week in July and that P7's SW-A, had called her with concerns. She also mentioned that HHA-D was refusing to help P7 with some things because of her pregnancy like bending over, lifting, and moving furniture around. BOC-C stated she then talked with P7 and told her I told her we could find her someone else and that P7 stated said she would like that. BOC-C further stated that during a meet and greet for a new staff that would be starting with P7, P7 stated how horrible she felt about HHA-D, that she had felt very intimidated, if she asked HHA-D to do something, she would tell her, too bad I am not going to do it.</p> <p>During subsequent phone interview on 11/5/19, at 8:30 a.m. P7 stated, "[HHA-D] was supposed to help me with minimal personal cares, and house work. I couldn't use her as a PCA because she made her too uncomfortable. She reported that half the time she had to run around with one sock on because she couldn't get it on. [P7] also stated she was very worried about who would help her, and stated [HHA-D] was a good housekeeper without the mental mind games." P7 stated HHA-D would run away from her with her laundry basket and shove 3 loads in the washing machine. P7 futher stated she would cry and HHA-D would half smile at her.</p>	G 488			

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G 488	<p>Continued From page 54</p> <p>During interview on 11/5/19 at 1:32 p.m., CM-A verified P7 is a current client receiving services, 2 hours 3 times a week. It would be in your job description to bend over and lift things to provide care for P7. CM-A indicated that no one ever reported that to her. That she would expect with neglect of care or any other abuse, maltreatment for the BOC's to be reporting this to the State Agency (SA). They are mandated reporters. Then they would report to me. Then you immediately remove the alleged perpetrator (suspend) pending the outcome of the investigation. CM-A stated HHA-D currently works with 4 other clients, and that CM-A was going to look into this immediately.</p> <p>The agency's Service Policies C.22 Vulnerable Clients, updated 6/28/18, indicated Purpose Adults: 1. To protect individuals who, because of physical or mental disability or dependence on home health services, are particularly vulnerable to abuse or neglect. 2. To ensure a safe living environment for vulnerable individuals who are receiving services. 3. To identify within the client's home all potential areas that might contribute to vulnerability and include corrective measures in the care plan. 4. To provide protection to individuals reporting abuse or neglect within the parameters of the law. 5. To require the reporting of suspected maltreatment of vulnerable adults to the statewide common entry point and to provide the completed investigation information to them when requested. Policy: It is the policy of International Quality Homecare (IQH) to protect clients who are vulnerable to neglect, abuse, or maltreatment due to physical or mental disability. All IQH staff, including volunteers and temporary workers are mandated reporters. A mandated reporter is anyone who comes in contact with a</p>	G 488			

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G 488	Continued From page 55 vulnerable adult or child. All clients receiving care (with the exception of homemaker only) are considered to be vulnerable adults. Internal Reporting Procedure 10. If an employee is the suspected abuser, the employee is removed from the home and will be removed from any other scheduled home care services during the investigation. The employee will be informed not to have any contact with the vulnerable adult or minor to prevent retaliatory issues from occurring.	G 488			



Dudley & Smith, P.A.
Attorneys and Counselors at Law

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December 13, 2019

Joseph J. Dudley, Jr.
jdudley@dudleyandsmith.com

Via Electronic Mail at kathleen.lucas@state.mn.us

Kathleen Lucas, Unit Supervisor
St. Cloud B. Survey Team
Licensing and Certification Program
3333 Division Street, Suite 212
St. Cloud, MN 56301-4557

Re: Project Number H8078023C, H8078024C, H8078025C, H807026C, H8078027C,
H8078028C, H8078029C – International Quality Homecare

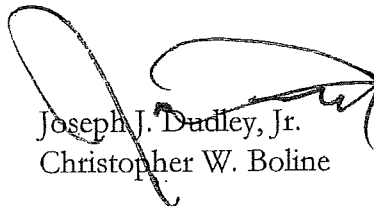
Dear Ms. Lucas:

Our office has been retained to represent International Quality Homecare in the above-entitled matter. Pursuant to a letter and complaint drafted by Douglas Larson, Enforcement Specialist, Minnesota Department of Health, Licensing and Certification Program, dated December 5, 2019, my clients have complied with his request and the statutory request in preparing a PLAN OF CORRECTION in accordance with the requirements as set forth under 42 CFR 484.50 and addressing the State's immediate concerns under that legal provision. I have enclosed a copy of my client's proposal for your information.

If you have any questions, please don't hesitate to contact me.

Very truly yours,

DUDLEY AND SMITH, P.A.



Joseph J. Dudley, Jr.
Christopher W. Boline

JDJ:wsm
Enclosure

cc: International Quality Homecare



Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail # 7016 2070 0000 7235 0792

December 10, 2019

Administrator
International Quality Homecare
3261 19th St Northwest
Rochester, MN 55901

Re: Enclosed State Licensing Orders - Project Number 2N1911

Dear Administrator:

A survey of the Home Care Provider named above was completed on , for the purpose of assessing compliance with State licensing regulations. At the time of survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these regulations that are issued in accordance with Minnesota Statutes, sections 144A.43 to 144A.482.

In accordance with Minnesota Statute section 144A.477, for home care providers that are licensed to provide home care services and are also certified for participation in Medicare as a home health agency under Code of Federal Regulations, title 42, part 484, with survey and enforcement by the Minnesota Department of Health as an agent for the United States Department of Health and Human Services, the requirements under Minnesota Statute section 144A.477 subd. 2 (1) to (16) are considered equivalent to the federal requirements. Because International Quality Homecare is a certified home health agency, violations of the requirements under Minnesota Statute section 144A.477 subd. 2 (1) to (16) may lead to enforcement actions under Minnesota Statute section 144A.474. If International Quality Homecare fails to comply with all of the federal deficiencies issued as a result of this Department's survey completed on , the findings supporting the federal violations shall be considered violations of the applicable licensure requirements. The notice of termination from the Medicare program by the Centers for Medicare and Medicaid Services (CMS) or the failure to attain compliance with the federal regulations within the time periods approved by CMS may constitute grounds for the revocation, suspension or nonrenewal of the license.

State licensing orders are delineated on the attached Minnesota Department of Health order 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 is 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."

We urge you to review these orders carefully. If you have questions, please contact the supervisor listed below. When all orders are corrected, the order form should be signed and returned to this

office at:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minnesota Statutes, section 144A.474, subd. 8 (c), by the correction order date, the home care provider must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction orders in future surveys, upon a complaint investigation, and as otherwise needed.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. 144A.474, subd. 12, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine(s) assessed. **The written request for reconsideration and all supporting documents must be received by the Commissioner within 15 calendar days of the correction order receipt date.** The Commissioner shall respond in writing to the request within 60 days of the date the provider requests a reconsideration. Any documentation received after the 15 calendar days will not be considered. You are required to send your written request and all supporting documents to Health.Homecare@state.mn.us; or, if you prefer you can mail it to:

Home Care Correction Order Reconsideration Process
Minnesota Department of Health/Health Regulation Division
P.O. Box 3879
85 East 7th Place, Suite 220
St. Paul, Minnesota 55101

Failure to correct state licensing correction orders may result in enforcement actions in accordance with the provisions of Minnesota Statutes, sections 144A.43 to 144A.482.

Please note, 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.

International Quality Homecare

December 10, 2019

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Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Douglas Larson", with a long horizontal flourish extending to the right.

Douglas Larson, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H20865	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2019
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NAME OF PROVIDER OR SUPPLIER INTERNATIONAL QUALITY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3261 19TH ST NORTHWEST ROCHESTER, MN 55901
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0 000	<p>Initial Comments</p> <p>*****ATTENTION***** HOME CARE PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>On 10/29/19, 11/1/19, 11/2/19, 11/4/19 and 11/5/19, surveyors of this Department's staff, visited the above provider and the following Correction Orders were issued:</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. 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> <p>When these state orders have been corrected, make a copy of these orders for your records and return the signed original to:"</p>	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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0 000	Continued From page 1	0 000	Minnesota Department of Health Licensing and Certification Health Regulation Division Kathy Lucas 3333 West Division Street, Suite 212 St. Cloud, MN 56301 Email: kathleen.lucas@state.mn.us	
0 265 SS=F	<p>144A.44, Subd. 1(2) Up-To-Date Plan/Accepted Standards Practice</p> <p>Subdivision 1. Statement of rights. (a) A person who receives home care services has these rights:</p> <p>(2) receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services;</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure 6 of 7 clients (P1, P2, P3, P5, P6, P7) were free from verbal abuse, neglect of care or financial exploitation, including failure to protect and thoroughly investigate. This had the potential to affect all patients served by this agency.</p> <p>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</p>	0 265		

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0 265	<p>Continued From page 2</p> <p>client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include:</p> <p>Findings include:</p> <p>P1's Plans of Care (POC) dated 7/16- 9/13/19 and 9/14- 11/2/19, indicated P1's start of care (SOC) was 5/22/18. P1's diagnoses included venous insufficiency, lymphedema and atrial fibrillation. The POC also indicated P1 was to receive skilled nursing visits 0-3 visits per week for 60 days for wound care, education about medication use and nursing staff to clean, dress, wrap lower extremities, monitor lower legs for any open areas. P1's POC also indicated P1 was oriented in relation to mental status.</p> <p>Review of a Common Entry Point Intake Form dated 10/14/19, indicated P1 had reported to the compliance department of the agency that registered nurse (RN)-A threatened to slap him, and he feared that she was going to. The report indicated P1 had reported RN-A had visited him on 8/16/19, after he had returned home from the hospital on 8/12/19. P1 stated he was supposed to go to rehab (rehabilitation), but had explained to RN-A he was not going to go because he had too much work to do around the house. P1 reported at that time, RN-A stated that someone should smack him across the face for turning that down, and P1 reported he felt RN-A was actually going to slap him. Further, the report indicated RN-A had been removed from P1's home and would no longer provide cares for P1.</p>	0 265		

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0 265	<p>Continued From page 3</p> <p>The agency's Internal Investigation Report, identified the following through interviews the agency had conducted: On 10/14/19, the compliance manager (CM)-A interviewed P1. P1 stated to CM-A, "The incident or close encounter was because I was supposed to do rehab. I mentioned that I couldn't go and she [RN-A] said to me, 'you ought to have your face slapped' for turning that down." P1 reported, "Her [RN-A] face was red, eyes enlarged, and I could smell her breath. I thought she was going to slap me. She is argumentative and once had to leave me to sit in her car for about ten minutes, I think it was to calm down. Every time she comes here, she raises her voice and is demanding." P1 reported the incident occurred on Friday August 16 (2019). P1 had further stated he felt threatened and stated, "Any minute I thought her hand was going to hit my face. I'm not sure why she didn't do it." According to the report CM-A asked if there were any additional incidents to where he felt threatened and P1 stated, "She cannot take no for an answer. She would get mad and argumentative. She would talk down to me and I don't like to be talked down to. We would argue so much that I would tell her to listen, get my legs done here and when you are done, get the hell out of here."</p> <p>The report indicated on 10/14/19, CM-A had interviewed RN-B. RN-B had reported, "A while ago [RN-A] told me she had gotten into an argument with [P1]."</p> <p>The documents indicated on 10/15/19, CM-A had interviewed RN-A. CM-A had asked RN-A about P1 and RN-A stated, "I went in to do his wound changes. He was angry with me. It started when I was training [licensed practical nurse (LPN)-A] and we didn't have enough supplies. We went</p>	0 265		

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0 265	<p>Continued From page 4</p> <p>into his closet and both of us were condensing his supplies. He was angry with me because it would take him months to find things." Documentaion indicated CM-A had asked RN-A about the day P1 stated he was supposed to go to for rehab and RN-A stated, "It was Mayo. It was good. [RN-B] and I both told him that this is bad. You need to go to rehab. One day I walked in and he was very angry. He threatened me saying, 'Just get in here and change my fucking wounds and get out.' I told him, 'you do not have to talk to me like that.' He yelled at me to just get in here and change my wounds. I went out to my car about five minutes to collect myself. I came back in and gave short answers, yes and no."</p> <p>The documents indicated on 10/17/19, CM-A had interviewed LPN-A. The documents indicated LPN-A had reported P1 told her RN-A had said she [RN-A] had half the audacity to smack him across the face.</p> <p>The Internal Investigation Report identified recommendations of compliance regarding the results of the investigation: "At the time of this report [RN-A] has been removed from giving any cares to [P1]. It is recommended that [RN-A] receive a write up for her actions in this event and review training on vulnerable adult and treatment to minors as well as boundaries. [RN-A] shall remain removed from [P1's] home.</p> <p>During interview on 10/29/19 at 1:07 p.m., P1 stated the incident with RN-A had occurred on Friday 8/16/19, when RN-A came to change the dressings for wounds on his legs. P1 stated, "The hospital wanted me to go to rehab, but I told her I couldn't go. She got real perturbed saying, 'You mean to tell me you turned that down?' When I told her 'Yeah I have too much to do' she got mad</p>	0 265		

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0 265	<p>Continued From page 5</p> <p>and said, 'You ought a have your face slapped', she was close to me, her face was real red, I could smell her breath and her eyes were as big as quarters. She Looked angry. I thought she was going to slap me, but she didn't. I think she had intent. Another time she got mad, walked out of the house and sat in her car fifteen minutes and I did not know if she was going to change the dressings on my legs. About a month or two ago she went into my bedroom, went through my medical supplies and tried to consolidate them. I had it in order so I told her to get the hell out of there, I have everything in order. I told her, 'Change the dressings since that is what you are here for.' She never asked permission to go into the bedroom. About every time she came out here, her and I would get in an argument. She was very negative, not very professional in actions or words. Most of the time she would start arguing about anything I would say. It got to be a pain in the neck. At first I did not report it to the home health agency, as I did not know what she was going to do. About August 27th, I mentioned it to the nurse that comes on Tuesdays. I told her that [RN-A] threatened to slap me and I asked for a different nurse to come on Fridays. She said, 'You should report this.' I called someone at the [agency] and reported it to them because the nurse on Tuesday told me to."</p> <p>The agency Schedule Verification for P1 identified on Friday 8/16/19, RN-A had provided services for P1. Start time of 10:33 a.m. and end time of 12:13 p.m.</p> <p>During interview on 11/1/19 at 2:57 p.m., LPN-A stated, "When I came into the office one day [RN-A] was freaking out because State was here. She said 'I know it's about [P1], because me and him got into an argument'. [RN-A] said she had</p>	0 265		

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0 265	<p>Continued From page 6</p> <p>to step away and go out and have a cigarette, because he made her mad. I just tried to calm her down because investigations happen all the time, because I did not know what happened. RN-A told me, him and her got into a verbal argument. The next time I went to visit [P1], he said they got into a verbal argument, she slammed the door and went outside to smoke and he said she had the half the audacity to smack him across the face, something like that." LPN-A had stated the day RN-A had informed her she had a verbal argument with P1, LPN-A had informed RN-B and did not know who else to report it to at the time. LPN-A stated, "I asked a friend what to do, [RN-B] and I talked to my friend, because it was bothering me and [RN-B] a lot." "I did not know who to talk to, as I did not know what staff here does what?" "My friend said we need to report it that is when we reported it." "I asked [RN-B] who she was going to report it to and she said she was going to email [administrator].</p> <p>An agency email dated Friday 10/11/19, at 4:35 p.m. sent from RN-B to the administrator, included RN-B had informed the administrator there were separate vulnerable adult and child situations related to RN-A. The first being P1. "She threatened to slap him and he actually feared she was going to. He would like to make a report with his details." The administrator had forwarded the email to CM-A on Friday 10/11/19, at 9:12 p.m.</p> <p>During interview on 11/4/19 at 1:20 p.m., RN-A stated, "[P1] and I have a history, we got along when I first started. My biggest problem with him, was he would tell me what the doctor wanted, but I never saw papers. He directed how to wrap his legs. One time I went in with another nurse [LPN-A] and we did not have all the supplies and I</p>	0 265		

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0 265	Continued From page 7 knew he had dressings in his bedroom. I asked if I could go back there. We found one small box of dressing sponges in a box. We made the comment we should condense these [supply boxes] as these are a home for cock roaches. We started to put things together, tossed things out of the room and he said don't be going in there rearranging things, so we stopped and took the supplies we needed and I showed [LPN-A] how to change the dressings on his wounds. The next time I went in there I basically got yelled at, because we had condensed things into a box and he said it would take months to reorganize it. I told him I apologize and it was not my intention to do that. We will have to make a concession that you have all the supplies in the living room so I don't have to go into the bedroom and get supplies." RN-A stated another time she went out to P1's house she was in a dress and P1 had stated, "Why are you dressed like that." RN-A said, "I had a dress on that day as [P1's] house is warm. I have an anxiety issue. I told [P1] I need a moment and he needed a moment and I left the house. I walked outside, went in the car and called the office. I reported to the branch office coordinator what had gone on. I told her I needed a moment and would go back in and dress his legs. That is what I did. I did not say much to him. I was short and said yes or no answers and did what he told me. He had come out of the hospital and they recommended he do some PT [physical therapy] and OT [occupational therapy]. I said to him, 'You could have made a better decision' and that I was disappointed in his decision. I know it got a little bit heated." RN-A stated, "You have heard about the three altercations I had with him. I felt uncomfortable working with him because he did not like me. As a team we tried to talk to him about changing days of the week [when P1's service visits were scheduled], as with scheduling	0 265		
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0 265	<p>Continued From page 8</p> <p>we were trying to schedule all [city] in one day to save time for the branch running to clients. He would not work out a compromise. Anytime I tried to talk to him it would turn into an argument, so we would make the days he was scheduled work." In addition, during the interview RN-A stated she had not heard from the agency what the recommendations from the investigation were, nor had she been provided any education.</p> <p>During interview on 11/1/19 at 10:15 a.m., CM-A stated RN-A had not been written up or had the training as documented in the investigation recommendations.</p> <p>P2's current POC dated 10/14-12/12/19, indicated P2's SOC was 12/18/18. P2's diagnoses included hypertension, type two diabetes, hypothyroidism and a very low level of personal hygiene. The POC also indicated P2 was to receive skilled nursing visits 0-1 visits per week for 60 days for management of medications.</p> <p>An agency email dated Friday 10/11/19 at 4:35 p.m., sent from RN-B to the administrator, included RN-B reporting there were separate vulnerable adult and child situations related to RN-A. The other being P2, who RN-A yelled at and told him how disgusting he lives. The administrator had forwarded the email to CM-A on Friday 10/11/19, at 9:12 p.m.</p> <p>Review of a Common Entry Point Intake Form dated 10/14/19, indicated it was reported to the compliance department of the agency that P2 had been yelled at by RN-A about how disgusting he lives. The report indicated P2 stated about two to three months ago RN-A had been abusive to him, not physically but verbally. P2 stated he did recall what was said but did not feel comfortable</p>	0 265		

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0 265	<p>Continued From page 9</p> <p>speaking to me (CM-A). P2 stated he believed the problem had been resolved because RN-A had not been coming there anymore.</p> <p>The agency Internal Investigation Report identified the following through interviews the agency had conducted: On 10/14/19, CM-A had interviewed P2. P2 was asked to explain the incident that occurred involving him and RN-A. P2 stated, "Well I am not really sure, it may be a personality conflict. I have been here 9 years. I have had a lot of nurses. [RN-A] has been abusive to me, not physically, just verbally. After a while, I didn't think I should have to go through this, so I called the Ombudsman." When asked what RN-A had said to him, P2 stated, "Yeah, I remember. I am not real comfortable sharing with you what she said. I just don't think I should be treated like that."</p> <p>On 10/14/19, CM-A had interviewed RN-B. RN-B reported she had overheard RN-A speak of how disgusting P2 lives. RN-B stated she had heard from LPN-A that RN-A had yelled at P2.</p> <p>On 10/15/19, CM-A had interviewed RN-A. CM-A had asked RN-A about P2. The documentation indicated RN-A stated, "I have seen [P2] last week. His room is pungent. I get stopped by residents that talk about how bad he smells. He has been receiving eviction notices. He is a slob." CM-A asked RN-A if she had mentioned that to P2 'in so many words,' RN-A said, "Yes I have. He throws his food and his incontinent pads not in the trash, but on the floor. His hair is knotted. His beard and clothes have dry milk and frosting. All of the homemakers have been told that he would shower another day. His floor is so sticky that your shoes stick to the floor. He called his social</p>	0 265		

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0 265	<p>Continued From page 10</p> <p>worker saying that he did not want me anymore."</p> <p>On 10/17/19, CM-A had interviewed LPN-A. LPN-A stated, "He [P2] says that she [RN-A] yells at him and calls him disgusting. Says she [RN-A] is rude ...she uses higher words I don't understand. Does not treat him with respect or dignity."</p> <p>The Internal Investigation Report also identified recommendations for compliance: "At the time of this report [RN-A] has been removed from giving any cares to [P2]. It is recommended that [RN-A] receive a write up for her actions in this event and review training on vulnerable adult and treatment to minors as well as boundaries. [RN-A] shall remain removed from [P2's] home."</p> <p>During interview on 11/1/19, at 1:27 p.m. P2 stated, "I reported this a month or two ago, it had been a while I was being verbally abused with her language. I reported to the Ombudsman and he talked to someone at the [agency]. The Ombudsman talked to someone at [agency] and they stopped sending [RN-A]. [RN-A] came one time a week to set up meds, order meds and pick up meds. She was verbally abusive about things. She talked about the condition of my apartment, personal condition and I told her I was taking steps to correct this. The basic thing she said was there is an aroma in your apartment. She harped on that a lot. I have a urinary incontinence problem and I wear undergarments to help. It's a medical problem and it's a real frustrating thing for me. It is terrible to be criticized by someone who is a health care worker. I have lived here for nine years and had a lot of nurses, and never had someone treated me like that. She should be aware of personal feelings I have and medical problems. The nurses told me before 'don't take a</p>	0 265		

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0 265	<p>Continued From page 11</p> <p>shower unless someone is in the apartment', so I waited each week for the housekeeper to be there when I took shower in case something happened. [RN-A] was complaining I was not taking care of my personal hygiene well enough, I have a body odor." "I said well I am taking a shower two to three times a week when the housekeeper was here. I felt I was being abused verbally by what she said. I thought the things she said were not necessary."</p> <p>During interview on 11/1/19, at 2:57 p.m., LPN-A stated before she started providing cares for P2, RN-A had told her, "How disgusting he is. That he pisses all over himself and the furniture. There is food everywhere. He is an extremely intelligent man but does not have any hygiene." LPN-A stated RN-A had stated, "We are not allowed to carry anything into the apartment with us. You go in there, you grab his pill thing and you walk out. You set up medication, take it back to him, he will look at them close up and put them away, he will sign paper and leave." "She said not to let him even use my pen." LPN-A stated RN-A had gone to P2's apartment on 10/8/19, to provide service for P2, as she was not able to work and had to take the day off." LPN-A stated, she had called P2 on 10/10/19, to see how he was doing and to make sure the visit went ok. LPN-A stated, "[RN-A] and [P2] had verbal arguments and he does not feel he is treated properly. She belittles him and does not treat him with any dignity or respect."</p> <p>During interview on 11/4/19, at 1:44 p.m. RN-A stated, "[P2] had a urine problem and threw his incontinent products on the floor. I did talk to him and said this was kind of disrespectful even for the homemakers. He should try to throw briefs in the garbage instead of towards the garbage can. I</p>	0 265		

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0 265	Continued From page 12 tried to talk to him about showering and doing so when homemakers are there. He agreed to that, but when following up with the homemakers on Monday, they report he would say he'd take one on Wednesday, and on Wednesday he'd say he would take one on Friday. So I did go in there and confront him. I told, 'You are 80 years old, I should not have to tell you need to take a shower.' I told him the homemakers had told me he was not showering. I know through the conversations we had I also said, 'I know they are going to be giving you an eviction notice.' I asked him to purchase his own blood pressure cuff because I did not want to use mine, which I use with other clients, because of his personal hygiene. There was one afternoon or morning I went in there to set up meds and I threw up, it made me physically sick. I told the social worker I could still set up meds if they couldn't find another nurse, but I couldn't do it in his apartment. The last time I went in there was when [LPN-A] was ill. I was supposed to set up meds. [P2] was going to go to a doctor appointment and he had dried milk on his beard, disheveled hair and dry frosting on his shirt. I suggested he clean up before goes to see the doctor. He becomes very defensive. He said, 'it's always you.' I stated, 'maybe you would want to know before you go see your primary doctor.' I know one time I lost my cool, I heard he was being evicted, had calls from daughter, the manager of the building and other residents saying can you take care of that stinking man. I was forceful, I was frustrated, I was everything in the world. I did yell at him, I said he was 80 years old and I should not have to come in and tell him he had to take a shower, or tell him 'this is why you are getting evicted.' This is why this is all happening, because of his poor personnel hygiene." RN-A also stated she still completes the Oasis assessments for P2, which requires her	0 265		
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0 265	<p>Continued From page 13</p> <p>to make a visit to see P2. RN-A stated, "I try to limit myself with seeing P2, as I know he does not feel comfortable with me, and I don't feel comfortable with him." RN-A confirmed she is still having contact with P2 every 60 days. RN-A stated she recently provided medication set up and completed an Oasis assessment for P2.</p> <p>The agency Schedule Verification for P2, identified on Wednesday 10/9/19, RN-A had provided services for P2. Start time of 4:54 p.m. and end time of 5:45 p.m.</p> <p>During interview on 11/1/19, at 10:15 a.m., CM-A stated RN-A had not been written up or had the training as indicated on the investigation recommendations.</p> <p>During interview on 11/5/19, at 8:18 a.m., CM-A stated the last day RN-A had provided services for P2 was 10/9/19. CM-A verified with the branch office in Rochester that RN-A was still P2's case manager. CM-A stated he was not aware RN-A was still assigned to be P2's case manager.</p> <p>During interview on 11/5/19, at 9:12 a.m., CM-A had called the branch office in Rochester and requested RN-B be assigned as case manager for P2 instead of RN-A.</p> <p>P3's current POC dated 9/2-11/25/19, indicated P3's SOC was 8/8/17. P3's diagnoses included illness and multiple sclerosis. The POC also indicated P3 was to receive skilled nursing visits 0-1 visits every week for 60 days for medication set up and assessment with three as needed visits for changes in health status and home health aide (HHA) 0-4 visits each week for 60 days to assist client with bathing, grooming, hygiene, dressing and transfers.</p>	0 265		

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0 265	<p>Continued From page 14</p> <p>Review of a Common Entry Point Intake Form dated 8/9/19, indicated a family member (FM)-C of home health aide (HHA)-B had called the agency office on the afternoon of 8/9/19, to report HHA-B had taken out a vehicle loan about a year ago and had the client, P3 co-sign for the vehicle. The family member FM-C became aware of it yesterday. FM-C also stated the car insurance was in P3's name and the client was paying the car insurance, not HHA-B.</p> <p>The agency Incident Report dated 8/9/19, at 3:45 p.m. identified the same as the Common Entry Point Intake Form.</p> <p>The agency Internal Investigation Report identified the following through interviews the agency had conducted: On 8/12/19, CM-A had interviewed P3. P3 stated she had driven her car to the car dealership to meet HHA-B and had co-signed for a car loan for HHA-B. P3 stated, "[HHA-B] had worse credit than me. She needed a car because she needed to get to all of her clients. That was very important to her." P3 stated HHA-B's FM-C was present at the car dealership.</p> <p>On 8/12/19, CM-A had interviewed HHA-B. HHA-B stated, in response to if she had P3 co-sign for a car loan, "Yes [P3] did, but I am paying for the vehicle." HHA-B stated this occurred "A year ago?" HHA-B stated, "My [FM-C] called [P3] and asked if she can help with the loan." HHA-B stated in response to who pays for the insurance, "I do." HHA-B stated in response to who's name is the insurance in, "It's in [P3], name, but I pay her for it." HHA-B stated FM-C was present at the car dealership, when P3 co-signed for the car loan.</p>	0 265		

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0 265	<p>Continued From page 15</p> <p>On 8/13/19, CM-A had interviewed detective (D)-D. D-D stated, "[HHA-B] admitted everything. She is not the loan payee. [P3] is paying."</p> <p>During interview on 10/29/19 at 2:50 p.m., P3 stated HHA-B did not have any credit and she needed a car. HHA-B's "family was there and told me to sign for the car loan." P3 stated this occurred back in 8/2018. P3 stated HHA-B has worked with her for five years. P3 stated HHA's FM-C would come and do HHA-B's job (give her a shower and do household work) when HHA-B could not make her scheduled visit due to being at another client's house. P3 stated FM-C was not an employee of the agency, but HHA-B was. P3 stated the agency was not aware of this. P3 stated she was the primary signer for the car loan and HHA-B was the co-signer and the insurance for the care was under her name. P3 stated, "[HHA-B] paid the car loan and I paid the insurance monthly." P3 stated HHA-B had approached her first to ask me to sign on the car loan. P3 stated HHA-B and FM-C had both asked for her to pay for the car insurance as they could not afford to due to having to pay insurance on another vehicle.</p> <p>During interview on 10/29/19, at 3:12 p.m., HHA-B stated FM-C was present when the car was purchased. The car loan place told me I needed a co-signer and FM-C stated why don't you ask P3. P3 co-signed on a loan for the car and the insurance was under P3's name. I paid the \$115.00 a month for the car insurance to her and I paid the car loan of \$279.00 a month. The car loan was in both of our names. HHA-B stated at the time of the incident she was an employee of the agency and had provided services of shower, cleaning house and shopping for P3 for about two years. HHA-B stated FM-C had gone to</p>	0 265		

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0 265	<p>Continued From page 16</p> <p>P3's home to do her job (as scheduled by the agency) for the day of providing a shower to P3, due to she was busy with another client and could not get there at the scheduled time. HHA-B stated the home care agency was not aware FM-C was at P3's home in place of her.</p> <p>During interview on 10/29/19, at 3:23 p.m. CM-A said in regards to whether the agency was aware FM-C had been in P3's home providing cares to P3 in place of HHA-B, CM-A said, "We were told that by the police department and determined it was not accurate. I am going to be honest with you. I don't believe any of this. The client (P3) did not report any of this until after she found out that [FM-C] had reported [HHA-B]. We found out about this through the police department, not through her [P3]. This was like a roller coaster going through liquidation of a divorce. He found out about the client co-signer on the car loan when the divorce started and decided to be a good citizen and report it to us. There was no proof he was ever in the house of the client."</p> <p>During interview on 11/4/19, at 10:20 a.m., RN-C stated FM-C had informed her of HHA-B having had P3 co-sign on a car loan and stated she knew P3 was also carrying the insurance. RN-C stated she had never heard of FM-C providing cares for P3 when HHA-B could not be there. "I know a lot of times [HHA-B] and [P3] made up their own schedule and we (agency) would not know about the changes or the times of when the visits were scheduled to be done with the changes."</p> <p>During interview on 11/4/19, at 2:39 p.m. FM-C stated at the car dealership HHA-B was dealing with obtaining the car loan. We were there all day long and I stepped out to have cigarettes. I don't</p>	0 265		

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0 265	<p>Continued From page 17</p> <p>know what happened and we drove out of there with a car. FM-C stated he did know who P3 was and stated, "I have been over to her place. We (HHA-B and self) were coming back into town and HHA-B had to be there, so we just stopped instead of dropping me off at home first. She did her work and we left. FM-C stated this occurred a couple of times. We would have to go or come from a doctor appointment or something and would stop at P3's house for HHA-B to do her job. FM-C confirmed he was not an employee of the agency at the time and when in P3's home had not provided cares for P3. FM-C stated he did not know how P3's name was on the title of the car P3 was not at the dealership the day the car was purchased. FM-C stated the insurance for the car was supposed to be transferred from his truck to the car and somehow P3's name ended up being on it.</p> <p>During interview on 11/5/19, at 9:59 a.m. CM-A stated he was not aware FM-C was present in P3's home when HHA-B was scheduled to be providing cares.</p> <p>During interview on 11/5/19, at 1:24 p.m. the administrator verified the date and time of the email regarding P1 and P2. The administrator stated she would not be surprised if the incidents did not get reported to the State Agency until Monday, "I don't think anybody is checking emails over the weekend. Everyone is a mandated reporter and I would have expected [RN-B] to have filled out an incident report and report the incidents to the State Agency." The administrator stated she was not aware what the recommendations of the investigations for P1 and P2 were in regards to RN-A.</p> <p>P5 financial exploitation</p>	0 265		

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0 265	<p>Continued From page 18</p> <p>P5's Personal Care Attendant (PCA) Service Plan dated 4/20/18, indicated P5 received PCA services 23 hrs per day. P5's Homecare Service Plan dated 4/20/18, indicated P5 received HHA services 3 visits daily.</p> <p>P5's POC for the certification period from 4/15-6/13/19, indicated P5 was admitted to the agency on 4/20/18, with diagnosis of early-onset cerebellar ataxia (symptoms of an inability to coordinate balance, gait, extremity and eye movements), type 2 diabetes, paroxysmal atrial fibrillation, hypertension, chronic obstructive pulmonary disease (COPD), and tobacco use. The POC also indicated P5 was to receive skilled nurse visits 1 per week and 3 as needed (PRN) visits for possible change in condition x 60 days, and home health aide (HHA) 0-3 visits each week x 60 days. P5's HHA care plan dated 7/6/19, identified the HHA would assist with bathing, dressing, grooming, transfers, and housekeeping. P5 was discharged from the agency on 6/7/19.</p> <p>Review of Common Entry Point Report Form dated 5/1/19, indicated P5's county case manager (CCM)-A reported that P5 had reported that [HHA-A], went to get [P5] quarters so he could do his laundry. [HHA-A] said she only took \$20.00 in quarters and brought that to [P5], but the slip said \$40.00. This happened in October, 2018.</p> <p>Review of HHA-A's Employee Coaching and Counseling Notice dated 12/29/18, indicated the following concerns were reported regarding [P5], employee borrows and doesn't return [P5's] small personal items: lighter, batteries, Tupperware. The concern violates the rule of conduct 8.1.27 borrowing or taking any clients money or personal property. Correction expected: [HHA-A] will not</p>	0 265		

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0 265	<p>Continued From page 19</p> <p>borrow any items from [P5].</p> <p>During phone interview on 11/5/19, at 9:44 a.m. CCM-A stated, "I am currently [P5's] case manager. [P5] told me over the phone on 5/1/19, that [HH-A] took 40 dollars in quarters and only gave 20 dollars back, this happened back in October, 2018."</p> <p>Although an attempt was made to phone HHA-A on 11/5/19 at 10:31 a.m., the phone mailbox was full and could not accept messages.</p> <p>During a phone interview on 11/5/19, at 12:34 p.m. P5 stated, "[HH-A] went to get me 20 dollars in quarters so I could do my laundry and she took 40 dollars, that's what the receipt said. I don't know where the extra 20 dollars went. I reported it to the [branch office coordinator (BOC)-A] at International Quality Home care, she said she would see what she could do about it. I never did get my 20 dollars back. I stopped services in June, 2019, because International didn't have enough people to cover the 24 hour care when I needed it."</p> <p>During a phone interview on 11/5/19 at 2:10 p.m., the BOC-A stated, "I am no longer the BOC, my employment ended January, 2019. I do remember there was a money issue with [P5] and [HHA-A], she denied it ever happening. I told them no one is working until we get this taken care of. I am not sure, but I feel like it was resolved, otherwise I would have followed up with it more." BOC-A further stated "I did not report this to the State Agency."</p> <p>During phone interview on 11/5/19, at 2:30 p.m. Assistant Branch Operation Coordinator (ABOC)-A stated, "I do remember [P5] saying that</p>	0 265		

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0 265	<p>Continued From page 20</p> <p>[HHA-A] had taken money from him. [P5] did tell me about 20 dollars of quarters that [HHA-A] got out of him, but the receipt said 40 dollars was taken out. I did report that to [BOC-A] at that time. [BOC-A] told me that the team that worked there each gave [P5], 5 dollars to get him his money back and told me the problem was solved and there was no need to go any further. We never did figure out where the money went."</p> <p>During an interview on 11/5/19, at 3:17 p.m. Compliance Manager (CM)-A stated, if this would have been reported to me we would have immediately suspended [HH-A], pending an investigation. I would have expected the staff at the time to report this to the state agency (SA) as neglect of care, and then reported to me. CM-A verified patients working with HHA-A at that time were not questioned if they had the missing money and that HHA-A no longer employed with the agency.</p> <p>P5 Neglect of Care P5's PCA service Plan, dated 4/20/18, indicated P5 received PCA services 23 hrs per day. P5's HomecareService Plan dated 4/20/18, indicated P5 received HHA services 3 visits daily.</p> <p>P5's Schedule Verification for April, 2019, indicated there were 10 days where P5 did not receive 23 hours of PCA and HHA services: April 1, 2, 3, 12, 15, 17, 20, 23, 24, and 29th on the days that HHA-C had worked. No coverage provided from 2.5 to 3 hours on the days identified above in the afternoon.</p> <p>Review of a Common Entry Intake Form, dated 5/1/19, identified P5's county case manager (CCM)-A reported that P5 received 24 hour care,</p>	0 265		

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0 265	<p>Continued From page 21</p> <p>and about a month or so ago he had an accident- had wet his pants. The HHA had told P5 she had to leave early and did not put any clothes on him and put him to bed with only a sheet. HHA left at about 3:45 p.m. and the next staff was to arrive at 4:00 p.m., this staff never showed up. P5 stated that FM-C and FM-D showed up and FM-D called the agency and then a staff showed up to help him. P5 further reported that there has been 2 times when he came home from work, no staff was there to meet him and he has a hard time getting the door open to his building.</p> <p>On 11/5/19, at 9:34 a.m. phone interview attempted for FM-D, mailbox was full.</p> <p>During phone interview on 11/5/19, at 9:44 a.m. CCM-A verified she is currently P5's case manager. CCM-A stated, P5 has reported to me on 5/1/19, that about a month ago he was having some staffing issues and that he was left in bed with no pants on it and the staff never showed up. P5 was very embarrassed when his family members ended up showing up to help him. CCM-A verified P5 was unable to get out of bed on his own. CCM-A stated, P5 is in corporate foster care now, give him a call and he will be able to tell you more.</p> <p>During phone interview on 11/5/19, at 10:35 a.m. BOC-(D) stated, I started this position in March, 2019. P5 did not like HHA-C, she set the boundaries and the rules. P5 didn't like that she was by the book and he felt like she was trying to control him. I have never heard of any instance of P5 being left in bed by himself.</p> <p>During phone interview on 11/5/19, at 12:34 p.m. P5 stated, I can't remember who left me in the bed that day. She left me in bed and the next staff</p>	0 265		

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0 265	<p>Continued From page 22</p> <p>never showed up like the one girl said she would. I can't get out of bed myself. I pounded on the wall until someone came to help me. I lived in an apartment at that time. P5 further stated he stopped services in June because the agency didn't have enough people to cover the 24 hour care when I needed it.</p> <p>During phone interview on 11/5/19, at 12:57 p.m. registered nurse (RN)-D stated, she had worked here since February of 2017 and I was P5's RN case manager, that P5 went through a lot of staff and he had his favorites and personality conflicts with others. RN-D stated she was not aware of anyone not providing cares to P5 or being left in bed alone and that one ever shared that with her.</p> <p>On 11/5/19, at 1:05 p.m. attempted phone interview with FM-C, mailbox was full unable to leave message.</p> <p>On 11/5/19 at 1:07 p.m. attempted phone interview with to FM-D. This surveyor was given the wrong phone number.</p> <p>During interview on 11/5/19, at 1:15 p.m. CM-A stated P5 was a client we had 24 hour services with that he was not aware of any staffing issues with P5, no one ever reported anything to me and was not aware P5 was left in bed alone. CM-A further stated if a family member reported to the Branch office about neglect of care, the branch office should be reporting that to me. This is the first time he have heard of it, and that would have to report this as a VA for neglect of care.</p> <p>During phone interview on 11/5/19, at 2:10 p.m. BOC-A stated, I am no longer the BOC, my employment ended January, 2019. I don't remember ever talking to FM-C about P5 being</p>	0 265		

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0 265	<p>Continued From page 23</p> <p>left in bed by himself.</p> <p>During phone interview on 11/5/19, at 2:30 p.m. Assistant Branch Operation Coordinator (ABOC)-A stated, I do remember that P5 got into an altercation with HHA-C because there was new order to get P5 out of his wheelchair and lay on his side in the bed. He was getting pressure ulcers on his ankles, we were trying to work with him on that. HHA-C put P5 in the bed, she left early maybe by 15 to 20 minutes. HHA-C was reprimanded for leaving P5 in the bed that day. I have no idea why she left him there by himself, she told me P5 said he was fine with it. How I found out P5 was by himself was that his neighbor called me because he was knocking on the wall, he lived in an apartment building, and she lived across the apartment from him so she brought him the phone so he could call me. She called me before even going over there, she called to tell me she could hear knocking on the wall and she wanted to go check on him. I am not sure how she knew to call me. I then called P5's family members because I couldn't have gotten there in enough time. I wanted someone there right away. I was supposed to be there at 4pm, but I ended up getting there around 4:15 pm. He could be left alone in his home for 1 hour a day. My concern is, it was a safety concern because he could not get out of bed on his own, he had no phone, and if there was a fire he would not have been able to get help. He told me he was embarrassed because his family member could not get him out of the bed. He was in the bed with a shirt and his brief, he was not soiled or anything. I did immediately report this to BOC-A, that's when she sat with HHA-C and talked to her about it. I am not sure if it was formal or not. We got approval from P5's case manager for P5 to be left alone for an hour, she had taken him to</p>	0 265		

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0 265	<p>Continued From page 24</p> <p>the doctor, P5 wanted to be able to have personal time. My heart dropped when I got that phone call. P5 told me he was in the bed by himself, because anything could have happened. So I dropped everything and went to go be with him to make sure he was ok. I got there at 4:15 pm. HHA-C left 15-20 minutes early that day.</p> <p>On 11/5/19, at 3:12 p.m. attempted phone interview with HHA-C and an unidentified person stated this was the wrong phone number.</p> <p>On 11/5/19, at 3:17 p.m. CM-A stated, if this would have been reported to me we would have immediately suspended HHA-C, pending a thorough investigation. I would have expected the staff at the time to report this to the SA as a neglect of care, and then report it to me.</p> <p>On 11/5/19, at 3:33 p.m. human resources director (HRD) verified there were no write-ups in HHA-C's personnel file.</p> <p>P6 financial exploitation P6's POC for the certification period from 10/6/19 to 12/4/19, identified P6 was admitted to the agency on 10/11/18, with diagnosis of chronic pain syndrome. The POC also identified P6 was to receive skilled nurse visits 1 per week x 60 days and home health aide (HHA) 0-6 hours per week. P6's HHA care plan dated 11/4/19, identified HHA will assist with bathing, grooming, hygiene, transfers, mobility, meal prep, and light housekeeping.</p> <p>P6's Client Supervisory Note, dated 6/6/19, identified P6 was not satisfied with services, thinks HHA is stealing money from him, made incident report while in home and sent to compliance.</p>	0 265		

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0 265	<p>Continued From page 25</p> <p>Agency, Incident report dated 6/6/19, indicated date incident occurred was on 6/5/19, time it occurred was, "many." Date reported to RN-A was on 6/6/19 at 1:00 p.m. Type of incident reported was property lost/stolen/destroyed and financial exploitation. Incident that occurred: On 6/6/19, P6 reported to me (RN-A), that P6 thought HHA-E was stealing money from him. It started on 5/15/19 when 20 dollars was missing from underneath the salt shaker. P6 had placed 80 dollars there for a privately hired employee, or at least he thought he had, and chalked it up to forgetfulness. The next time HHA-E worked was 5/22/19, again 80 dollars was placed under the salt shaker, and again 20 dollars was missing. On 5/29/19, again 80 dollars was placed underneath the salt shaker in different denominations then 10 dollars was missing, P6 stated, Perhaps I made a mistake, there were many different bills, maybe I counted wrong. Did I really make that mistake? Am I losing it? P6 reported this was about the time he noticed two 100 dollar bills missing, he had them stashed in his wallet that was placed next to the table in his easy chair. P6 stated on 6/1/19, he went to the bank and got 300 dollars and put it in his wallet. On 6/5/19, before HHA-E came into the home, P6 and his spouse counted out 80 dollars and placed it under the salt shaker, then HHA-E came to work. P6 noticed when she was taking the laundry to the kitchen she stopped, put the laundry basket on the table, fiddled with her phone and then continued on into the kitchen. When his privately paid worker showed up they both counted the money, there was 20 dollars missing. When P6 checked his wallet, the 300 dollars he had just gotten was missing and he went nowhere to spend it. Also reported that P6 kept extra cash in a dresser drawer in his</p>	0 265		

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0 265	<p>Continued From page 26</p> <p>bedroom and 40 - 80 dollars was missing from there. Reported to compliance, made incident report, will be pulling HHA-E from the home until further investigation. Action taken to prevent occurrence was client could keep his cash in a more secure location.</p> <p>An additional agency, Incident report was filed by RN-A dated 6/6/19, identifying the date of the incident on 6/5/19, at 10:00 am. Report further indicated the theft was not reported to the police.</p> <p>Review of the Common Entry Point Report Form, dated 6/7/19, identified CM-A reported that P6 reported to RN-A on 6/5/19, that P6 had 20 dollars taken off his table and 200 dollars from his wallet, on 5/29/19, 10 dollars was taken, 5/15/19, 20 dollars was taken and on 6/5/19, 20 dollars was taken off of his table, 300 dollars from his wallet and 40 to 80 dollars off of his dresser. HHA-E was the alleged perpetrator.</p> <p>An Agency Internal Investigation Report dated 7/3/19, identified an incident occurred 6/6/19. Date report came into compliance was 6/6/19. Dates of investigation were 6/6/19 to 7/3/19. P6 was interviewed. HHA-E was interviewed and verified she worked for P6 on Mondays, Wednesdays and Fridays for a month. HHA-E stated, "I took the 20 dollars the one time, but no other time. My brain may not have thought about it. I saw it and a bad light went on. I was on E and needed gas." Recommendations of the compliance officer regarding the results of the investigation: after the interview with HHA-B, compliance recommends termination of employment. This recommendation will be brought to the director of human resources.</p> <p>During phone interview on 11/1/19, at 2:19 p.m.</p>	0 265		

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0 265	<p>Continued From page 27</p> <p>P6 stated, back in May, I had a home health aide come every Wednesday to help me, I would put out money for my housekeeper and paid the housekeeper \$80 every week. So I would set the money out on the table underneath the salt shaker. Well the money I left out for the housekeeper kept coming up short. On 5/8/19, I was missing 20 dollars off the table and 200 dollars from my wallet, On 5/15/19, 20 dollars was taken, on 5/29/19, 30 dollars was taken, on 6/5/19, 20 dollars was taken off the table, 300 dollars out of my wallet, and 40- 80 dollars was taken off of my dresser. "I thought I was going senile." The last 2 weeks that HHA-E was here, my wife and I counted the money and on both instances we were 20-30 dollars a week short. When I suspected something was going on, I had my wallet next to me in the living room and I always keep two 100.00 dollar bills in my wallet, because sometimes I wouldn't leave my house for 3 -4 weeks at a time, then I would need to pay someone for something and then my money would be gone. I reported this to the company, and they never did get back to me. The nurse that comes here once a week, (RN-A), she is the one who told me that HHA-E admitted that she took my money all those times and they had to let her go. It made me feel better that she admitted it, I really thought I was losing it. My wife and I would count the money together because we both thought we were losing it. The agency never reimbursed me.</p> <p>During phone interview on 11/4/19, at 2:11 p.m. RN-A stated, "[P6] did report to me some missing money back in June. The homemaker was [HHA-E]. The first time [P6] told me he thought this happened, but could have made a mistake so let's just forget about it. He paid someone cash that was left on the table for the person to pick</p>	0 265		

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0 265	<p>Continued From page 28</p> <p>up. Whenever HHA-E came again, he counted the money with his wife. The guy that was getting paid, said he was missing 20 dollars. [P6] stated he just did not want her in the house anymore, so we took her out of the house at that point." RN-A stated she probably wrote in on a progress note, probably did not report this, he did not want me to. He said that 20 dollars would not make him or break him. He did mention that he was missing 200 dollars from his wallet on a couple occasions. What I got from him, he had so many people coming in and out of the house that he wasn't sure who did it. RN-A stated she reported incident to BOC-B and did not know the company policy on reimbursement and that P6 never mentioned the money or HHA-E again.</p> <p>During interview on 11/4/19, at 2:45 p.m. BOC-B stated P6 always reported to RN-A and then she would report to me. BOC-A stated she was made aware of P6's missing money once compliance was doing an investigation, was informed by compliance that he needed to reach out and let HHA-E know she was suspended to make sure she wasn't working with any clients. She was suspended for a week. After investigation they emailed and notified me to fill out and EOE, an end of employment, then it goes into her e-chart. HHA-E employment was ended on 7/1/19, at 3:45 pm, she was terminated effective immediately due to client incident report involving stealing of client money. At the end of investigation they found her to be guilty of stealing the money. Her last shift was 6/6/19. BOC-A stated did not get back to P6 about the missing money, that would be CM-A's job, she should follow up with client. BOC-A further stated our policy is we can ask the client if they want to press charges, we would file a report with police department was not sure but thought a police report was made.</p>	0 265		
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0 265	<p>Continued From page 29</p> <p>During interview on 11/4/19, at 3:28 p.m. CM-A stated, I was first notified of P6's missing money on 6/6/19. I reported this to MAARC on 6/7/19, at 4:16 p.m. Our policy is that everyone is a mandated reporter and they are to fill out the incident report and then report it to me and I will report it to the state. My suggestion to [P6] was to call law enforcement and [P6] told me, I am not sure I am inclined to do that. That requires a lot of time to go in and out of his house and he was not ready to do that. [P6] was real leery of [HHA-E], there was no definitive way he could prove it. He didn't feel this worker should be going into any other person's house. We suspended [HHA-E] on 6/7/19, at 4:51 p.m., indefinitely, she was termed on 7/1/19 at 3:45 pm. I don't recall if I ever got a chance to let [P6] know what the results of the investigation were. CM-A verified HHA-E took care of other clients during that time frame, and CM-A verified he did not check with the other clients to see if they had any concerns with missing money. At 4:21 p.m. CM-A stated, we do not have a specific policy on resolution to financial exploitation. I did not report this to the police department. CM-A stated, the policy states if an incident is reported to MAARC and there is reason to believe a crime was committed, we should be immediately reporting this to law enforcement.</p> <p>During phone interview on 11/5/19, at 12:44 p.m. HHA-E stated, she did work with P6 and was aware of the reports of missing money that P6 was blaming her for taking a couple hundred dollars. HHA-E stated she did not take a couple hundred but had taken a twenty on his table and had admitted to taking that. HHA-E further stated the company is not good at communication, that CM-A had told me he had to</p>	0 265		

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0 265	<p>Continued From page 30</p> <p>report this. He said someone would be calling me at the end of the day. "They never called me again, so I assumed I was fired. I never did pay [P6] back. I didn't want to get in trouble for texting him, because [CM-A] told me I was not to have any contact with him. [P6] did end up texting me this big long paragraph and it made me feel bad, so I wanted to pay him back."</p> <p>P7's neglect of care P7's POC for the certification period from 4/3/19 to 4/1/20, identified P7 was admitted to the agency on 4/3/18, with diagnosis of type 2 diabetes mellitus, chronic obstructive pulmonary disease (COPD), and major depressive disorder. The POC also identified P7 was to receive personal care attendants (PCA) 0.6 to 3 hours of service every day x 12 months.</p> <p>P7's undated PCA care plan, identified PCA would assist with bathing, dressing, undressing, grooming, mobility, transfers, mood/behavior, light housekeeping, meals and medications.</p> <p>P7's Supervisory Note dated 7/16/19, indicated P7 was not satisfied with her services, HHA-D is chronically late and argues with client. "[P7] doesn't want to change workers, [HHA-D] threatened to leave the client. Worker argued with client."</p> <p>Review of Employee Coaching and Counseling Notice dated 7/17/19, identified a verbal warning to HHA-D and indicated a concern: clients have been concerned about HHA-D taking her maternity leave and want to know when her last day will be. This has been brought to my attention more than once and RN-E has also talked with HHA-D and HHA-D stated that she doesn't know why her clients are stating this. She</p>	0 265		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H20865	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2019
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NAME OF PROVIDER OR SUPPLIER INTERNATIONAL QUALITY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3261 19TH ST NORTHWEST ROCHESTER, MN 55901
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0 265	<p>Continued From page 31</p> <p>claims that she has not said anything to them to make them think that. P7 reported to LPN-B that HHA-D refused to do things her way and said, "If you don't like the way I am doing things, I will leave and not come back because I am taking maternity leave." This concern violates the following company policy: be involved in verbal argument in front of customers, insubordination-refusal to comply with instructions of a supervisor or other deliberate and inexcusable refusal to obey a reasonable order which relates to an employee's job function. Correction expected: I expect this rumor to stop. I expect clients to feel secure and satisfied with services and not have the concern on their mind about losing their aide when that is not true. I expect HHA-D to follow proper procedures and care plan when providing cares. If HHA-D doesn't agree with client about a certain task it needs to be brought to my attention or another staff member.</p> <p>Review of a Common Entry Point Intake Form dated 7/25/19, indicated P7 and her social worker (SW)-A met and P7 stated her PCA was emotionally abusing her. P7 was crying and couldn't understand why someone would do this to her. P7 reported she attempted to get a new PCA, but the agency could not provide this. HHA-D would intentionally ignore P7 when she would ask for physical assistance with tasks identified in P7's POC. P7 reported she would yell at HHA-D and would be ignored and HHA-D would tell P7 that she couldn't hear her even when in the next room, then she would smirk at her. HHA-D told P7 that she was pregnant and due any day so she could not complete tasks that would require bending over and refused to perform tasks identified in P7's POC. P7 then stated she called the agency to find out when</p>	0 265		

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0 265	<p>Continued From page 32</p> <p>HHA-D would be on maternity leave and they reported to her that HHA-D was not pregnant and is able to perform the tasks. P7 would communicate her needs to HHA-D and she would later tell P7 she did not say that. These recurring incidents made P7 feel like she was losing her mind. HHA-D later retracted statements per P7. P7 reported these incidents have caused her emotional stress and mental health instability which has resulted in a lack of trust for other providers to come into her home to assist her with tasks she needs.</p> <p>During a phone interview on 11/1/19, at 3:36 p.m. P7 stated, HHA-D started working with her during this last midwinter, that she had a hard time back then, that her car had been broken 3 times, wasn't getting much company, and HHA-D had her thinking she was going crazy. P7 stated one time, she told HHA-D not to do the laundry because there wasn't enough of it to do and that she wanted her to wait. P-7 stated HHA-D she put the basket of laundry above her head, where she couldn't reach it, that she told her not to, yet P7 ran and put it all in one load in the washing machine. P7 further stated she didn't want the colors and the whites mixed together. P7 also stated sometimes HHA-D would tell me she couldn't do anything that required bending down because she was pregnant and she would tell me, "I don't want to break the baby's neck." She had made my head running. P7 further stated sometimes she would pretend to not hear me when I would ask her something and pretend she was deaf, and then she would turn and smirk at me. When the agency finally realized what she was doing to me, they removed her from my home. However, HHA-D continued to work with me 3 or 4 more times after this had been reported because there was no one else to work with me.</p>	0 265		

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0 265	<p>Continued From page 33</p> <p>P7 also stated she just kept my mouth shut on those days and cried so much, "she had me thinking I was losing my mind". P7 went on to state, when HHA-D was working with her, she was begged her not to say anything on those days she was here, but it was too late, she had already told on her. P7 stated HHA-D doesn't work for me anymore and if she still did, she probably would be crazy .</p> <p>During phone interview on 11/4/19, at 9:49 a.m. registered nurse (RN)-E verified P7 received PCA services and stated, she opened her case, and she is a current client. A while back there was a PCA that P7 wasn't happy with. She did not like the one gal, it was HHA-D. HHA-D kept telling her clients she was pregnant and she would be leaving soon and that they would have to find someone else.</p> <p>During a phone interview on 11/4/19, at 10:03 a.m. LPN-B verified she did the supervisory visits for P7 back in July, 2019. They were having some issues, so RN-E had to take over. P7 complained about HHA-D, she said she was a good worker but she liked doing things her own way. LPN-B stated P7 did report to her that HHA-D told her she was pregnant. LPN-B verified on 7/16/19, a supervisory visit was completed and P7 did tell her several times that HHA-D liked to do things her way, then P7 would suggest a different way and HHA-D would tell her she was pregnant and wouldn't be working with her for very long anyways. LPN-B further stated she should have reported this to my branch office coordinator, could not remember if she did or not.</p> <p>During phone interview on 11/4/19, at 10:55 a.m. BOC-C stated, she has worked here since 2014, that she did talk to P7 the first or second week in</p>	0 265		

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0 265	<p>Continued From page 34</p> <p>July and that P7's SW-A, had called her with concerns. She also mentioned that HHA-D was refusing to help P7 with some things because of her pregnancy like bending over, lifting, and moving furniture around. BOC-C stated she then talked with P7 and told her I told her we could find her someone else and that P7 stated said she would like that. BOC-C further stated that during a meet and greet for a new staff that would be starting with P7, P7 stated how horrible she felt about HHA-D, that she had felt very intimidated, if she asked HHA-D to do something, she would tell her, too bad I am not going to do it.</p> <p>During subsequent phone interview on 11/5/19, at 8:30 a.m. P7 stated, "[HHA-D] was supposed to help me with minimal personal cares, and house work. I couldn't use her as a PCA because she made her too uncomfortable. She reported that half the time she had to run around with one sock on because she couldn't get it on. [P7] also stated she was very worried about who would help her, and stated [HHA-D] was a good housekeeper without the mental mind games." P7 stated HHA-D would run away from her with her laundry basket and shove 3 loads in the washing machine. P7 futher stated she would cry and HHA-D would half smile at her.</p> <p>During interview on 11/5/19 at 1:32 p.m., CM-A verified P7 is a current client receiving services, 2 hours 3 times a week. It would be in your job description to bend over and lift things to provide care for P7. CM-A indicated that no one ever reported that to her. That she would expect with neglect of care or any other abuse, maltreatment for the BOC's to be reporting this to the State Agency (SA). They are mandated reporters. Then they would report to me. Then you immediately remove the alleged perpetrator</p>	0 265		

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0 265	<p>Continued From page 35</p> <p>(suspend) pending the outcome of the investigation. CM-A stated HHA-D currently works with 4 other clients, and that CM-A was going to look into this immediately.</p> <p>The agency's Service Policies C.22 Vulnerable Clients, updated 6/28/18, indicated Purpose Adults: 1. To protect individuals who, because of physical or mental disability or dependence on home health services, are particularly vulnerable to abuse or neglect. 2. To ensure a safe living environment for vulnerable individuals who are receiving services. 3. To identify within the client's home all potential areas that might contribute to vulnerability and include corrective measures in the care plan. 4. To provide protection to individuals reporting abuse or neglect within the parameters of the law. 5. To require the reporting of suspected maltreatment of vulnerable adults to the statewide common entry point and to provide the completed investigation information to them when requested. Policy: It is the policy of International Quality Homecare (IQH) to protect clients who are vulnerable to neglect, abuse, or maltreatment due to physical or mental disability. All IQH staff, including volunteers and temporary workers are mandated reporters. A mandated reporter is anyone who comes in contact with a vulnerable adult or child. All clients receiving care (with the exception of homemaker only) are considered to be vulnerable adults. Internal Reporting Procedure 10. If an employee is the suspected abuser, the employee is removed from the home and will be removed from any other scheduled home care services during the investigation. The employee will be informed not to have any contact with the vulnerable adult or minor to prevent retaliatory issues from occurring.</p>	0 265		