

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL033836862M
Compliance #: HL033831355C

Date Concluded: February 18, 2025

Name, Address, and County of Licensee

Investigated:

Augustana Home Health Care
901 4th Avenue North
Minneapolis, MN 55405
Hennepin County

Facility Type: Home Care Provider

Evaluator's Name: Lisa Coil, RN, BSN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Investigation:

The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):

The alleged perpetrator (AP), who was a nurse, financially exploited clients #1, client #2, client #3, client #4, client #5, client #6, client #7, client #8, client #9, client #10, client #11, client #12, client #13, client #14, client #15, client #16, client #17, and client #18, when the AP diverted controlled substance medications from the clients.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined financial exploitation was inconclusive for 10 of 18 client (client #6, client #9, client #11, client #12, client #13, client #14, client #15, client #16, client #17, and client #18) charts reviewed. While a review of these documents indicated medication may have been diverted there was not sufficient evidence to demonstrate drug diversion took place and/or if the AP was involved in the diversion.

The Minnesota Department of Health determined financial exploitation was substantiated for 8 of 18 clients (client #1, client #2, client #3, client #4, client #5, client #7, client #8, and client #10). The AP was responsible for the maltreatment.

The investigation identified inconsistencies involving the AP regarding how controlled substances were accounted for which included undocumented medication destruction, unexplained adjustments in medications counts, and/or medications removed from the narcotic storage but not subsequently documented as administered.

The investigator conducted interviews with facility administrative staff. The investigation included review of the client records, pharmacy records, and facility internal investigation.

All the clients received comprehensive home care services, and all their services plans indicated the licensee provided medication management.

During an interview a manager, who was also a nurse, stated the licensee used two different narcotic books for documenting controlled substances. The manager stated:

- The first book was kept in the nurse's office/central storage for extra stock, which will be referred to as "central storage" below.
- The second book was used for administration by staff on the floor, which will be referred to as "floor administration" below.

During an interview, the AP stated she mainly worked Monday through Friday from 7:30 a.m. to 4:00 p.m. The AP stated her role included staffing items (interviewed, hired, fired, and trained), oversaw the residents (completed assessments and held care conferences), and took care of family complaints. The AP stated she did not administer medications daily but just as needed medications or when they were short staffed. The AP stated it was the responsibility of the licensed practical nurse (LPN) to do medication cycling (check in medications from the pharmacy). The AP stated when narcotics came from the pharmacy, they were double locked in the LPN office, also considered central storage. The AP stated the LPN would bring narcotics from central storage to the floor when needed.

The following examples of documentation indicative of diverted medications occurred over the course of greater than one year. The times give include only month, date, and time (as needed). The entries in the narcotic book were handwritten and not computer time-stamped whereas documentation in the electronic medical record included computer timestamps.

Client #1

Example 1

A pharmacy delivery packing slip indicated the licensee received 12 hydrocodone/Acetaminophen (APAP) 5-325 mg tablets (Norco) on January 14.

The electronic medication administration record (EMAR) indicated the client could have one to two tablets of Norco every four hours as needed.

The central storage narcotic book page indicated ten Norco tablets were received on January 14.

The only entry in the narcotic book page indicated [ten tablets] were put on the floor with zero tablets remaining on January 26.

The page had a large "X" through it and the bottom section labeled Disposition of Unused Drug was blank. No documentation was identified indicating the relocation/disposal of the other two Norco tablets.

The floor administration narcotic book page indicated four Norco tablets were received on January 26. This page had three entries.

The first entry on this page indicated the AP removed one tablet on January 26, at 1:30 p.m.

The second entry on this page indicated the AP removed two tablets January 26, at 6:00 p.m.

The third entry on this page indicated the AP removed one tablet on January 26, at 11:00 p.m.

The resident's EMAR did not indicate any of these three doses were administered to the client.

Example 2

A pharmacy delivery packing slip indicated the facility received 60 hydrocodone/APAP 5-325 mg tablets (Norco) on June 21.

The medication pass detail indicated the client had hydrocodone/APAP 5-325 mg, one tablet, scheduled twice.

The central storage narcotic book page for Norco had six entries.

The first entry on this page indicated 30 Norco were moved to the floor on June 21, leaving 30 Norco tablets remaining.

The second entry on this page indicated the AP documented removing one Norco on June 22, at 8:00 a.m.

The EMAR indicated a different person documented giving the client that scheduled dose, not the AP.

The third entry on this page indicated the AP documented removing one Norco on June 28, at 8:00 a.m.

The EMAR indicated a different person documented giving the client that scheduled dose, not the AP.

The fourth entry on this page indicated the remaining 28 tablets of Norco were moved out to the floor on June 24, leaving the amount remaining listed as 0.

The fifth entry on this in page indicated there were “order changes.” Twenty Norco were removed from the floor on July 1, listing the amount remaining as 20.

The sixth and last entry on this page indicated 20 doses “D/C.” The amount remaining was listed as zero on July 8 and was documented by the AP. There was not a second signature present to verify destruction of the medication. The Disposition of Unused Drug section at the bottom of the page was also blank.

The medication pass detail indicated the client’s Norco medication pass occurred 21 times accounting for 21 of the 60 Norco tablets.

A review did not identify the relocation/disposal for the rest of the 60 Norco tablets.

Client #2

Example 1

A pharmacy delivery packing slip indicated the facility received 56 hydrocodone/APAP 5-325 mg (Norco) tablets on July 17.

The floor administration narcotic book indicated the AP made an entry for a count correction. On the second narcotic page, following the twenty-third entry, the AP lowered the Norco count by one tablet. The entry for the correction was undated, included no other initial nor signature, nor a reason for the correction.

A review of the count in the narcotic book identified no mathematical errors which required this correction.

Client #3

Example 1

A pharmacy delivery packing slip indicated the facility received 30 tablets of APAP/Codeine 300-30 mg (Tylenol with codeine) on June 18.

The floor administration narcotic book page indicated 29 Tylenol with codeine tablets were received on July 8.

A review identified no documented relocation/disposal or explanation regarding the decrease count from 30 to 29 tablets from the time received from pharmacy until the time the tablets were checked in.

The floor administration narcotic book page indicated the client had one Tylenol with codeine tablet scheduled one time per day as needed. The narcotic book page had 20 administration entries which accounted for 20 of the 30 Tylenol with Codeine tablets. Additionally, the page had an "x" drawn through the length of the page with the AP's initials at the bottom.

No further documentation regarding the relocation/disposal of the remaining balance of the nine tablets was entered in the Disposition of Unused Drug section at the bottom of the document. However, there was illegible handwritten comment at the bottom of that page.

Example 2

A pharmacy delivery packing slip indicated the facility received 30 tablets of APAP/Codeine 300-30 mg (Tylenol with codeine) on February 11.

The narcotic book page, unknown if it was from central storage or floor administration indicated 30 Tylenol with codeine tablets were received on February 13. The page indicated the client had Tylenol with codeine available one time a day as needed for pain. The narcotic book page had six entries.

The first entry on this page indicated the AP documented removing one Tylenol with Codeine on February 13 at 8:30 a.m.

The EMAR did not indicate the dose was administered to the client.

The second entry on this page indicated the AP documented removing one Tylenol with Codeine on February 18 at 9:00 [a.m.].

The EMAR did not indicate the dose was administered to the client.

The fourth entry on this page indicated the AP documented removing one Tylenol with Codeine on March 18 at 2:00 p.m.

The EMAR did not indicate the dose was administered to the client.

The fifth entry on this page indicated the AP documented removing one Tylenol with Codeine on March 21 at 1:00 p.m.

The EMAR did not indicate the dose was administered to the client.

Following the fifth entry on this page, an entry indicated the AP destroyed 25 tablets on March 22 because the client moved out. The entry did not include a second signature for destruction of the medication.

No further documentation regarding the relocation/disposal of the remaining balance of twenty-five tablets was entered in the Disposition of Unused Drug section at the bottom of the document.

Client #4

Example 1

A pharmacy delivery packing slip indicated the facility received 30 oxycodone 10 mg tablets on August 22.

The floor administration narcotic book page indicated 30 oxycodone tablets were received on August 22. The page indicated the client had one oxycodone tablet scheduled every eight hours as needed for pain.

The narcotic book page had 17 administration entries which accounted for 17 of the 30 oxycodone tablets. Following the 17 administration entries were four additional and sequential entries:

The first non-administration entry indicated the AP “corrected” the count from ten to nine on July 3.

The second non-administration entry indicated the AP “fixed” the count from nine to seven on July 26.

The third non-administration entry indicated the AP “corrected” the count from seven to six on August 6.

No documentation regarding why three adjustments in the count was required over the course of approximately one month was identified.

The fourth non-administration entry indicated five tables were “destroyed” August 9 with an illegible signature.

Additionally, the page had a large “X” across the length of it and the words “moved [illegible]” wrote across the bottom six entry lines.

No further documentation regarding the relocation/disposal of the remaining balance of the five tablets was entered in the Disposition of Unused Drug section at the bottom of the document.

Client #5

Example 1

A pharmacy delivery packing slip indicated the facility received 14 oxycodone 5 mg tablets on July 2.

The EMAR indicated the client could have oxycodone one or two tablets (5-10MG) every four hours as needed from July 1 through July 15. Starting July 16, the order changed to oxycodone ½ tablet (2.5 mg) two times a day as needed.

The narcotic book page, unknown if it was central supply or floor administration, indicated 28 oxycodone tablets were received on July 2. The narcotic book page had 13 administration entries which accounted for 13 of the 28 oxycodone tablets. The ending balance indicated the count was 15 tablets, leaving two tablet unaccounted for.

The first handwritten entry listed the count as 27, which was mathematically correct since one tablet was removed on August 17.

The second handwritten entry dated August 18 at 9:00 a.m., has two numbers listed in the amount remaining column. The documentation for the count has a first number, which is partially crossed-out with a legible “2” and illegible number after it. Within the same entry, a second number was present listing the number of tablets remaining as “25”, which would be mathematically incorrect as the previous total was “27”.

The third handwritten entry, made by the AP, listed an incorrect dose and was crossed out. No explanatory note for the entry was provided.

The sixth entry on this page indicated the AP documented removing one oxycodone on August 20 at 8:00 a.m.

The EMAR did not indicate the dose was administered to the client.

The seventh entry on this page indicated the AP documented removing one oxycodone on August 20 at 12:00 p.m.

The EMAR did not indicate the dose was administered to the client.

The eighth entry on this page indicated the AP documented removing one oxycodone on August 20 at 4:00 p.m.

The EMAR did not indicate the dose was administered to the client.

The ninth entry on this page indicated the AP documented removing one oxycodone on August 20 at 8:00 p.m.

The EMAR did not indicate the dose was administered to the client.

The tenth entry on this page indicated the AP documented removing one oxycodone on August 22 at 8:00 a.m.

The EMAR did not indicate the dose was administered to the client.

The eleventh entry on this page indicated the AP documented removing one oxycodone on August 22 at 12:00 p.m.

The EMAR did not indicate the dose was administered to the client.

The twelfth entry on this page indicated the AP documented removing one oxycodone on August 22 at 4:00 p.m.

The EMAR did not indicate the dose was administered to the client.

The thirteenth entry on this page indicated the AP documented removing one oxycodone on August 22 at 8:00 p.m.

The EMAR did not indicate the dose was administered to the client.

Client #7

Example 1

A pharmacy delivery packing slip indicated the facility received 84 oxycodone 10 mg tablets on May 12.

Two pages in the narcotic books were used to document these medications.

The central storage narcotic page indicated 60 oxycodone tablets were received on May 12. The page included 22 entries.

The floor administration narcotic page indicated 24 oxycodone tablets were received on May 13. The page included 24 entries.

The fourth entry on the central storage narcotic page indicated one dose of oxycodone was administered by the AP on May 25 at 3:00 p.m.

The 21st entry on the floor administration narcotic page indicated one dose of oxycodone was administered by the AP on May 25 at 2:00 p.m.

The resident's EMAR for May 25 showed no documented administration of oxycodone at 2:00 p.m. or 3:00 p.m.

The fifth entry on the central storage narcotic page indicated one dose of oxycodone was administered by the AP on May 26 at 8:00 [a.m.]. However, the amount remaining count went from 52 to 50, leaving one tablet unaccounted for.

The 22nd entry on the floor administration narcotic page indicated one dose of oxycodone was administered by the AP on May 26 at 8:00 a.m.

The resident's EMAR indicated the AP did document administering one hydrocodone tablet on May 26, at 7:30 a.m.

The sixth entry on the central storage narcotic page indicated one dose of oxycodone was administered by the AP on May 26 at 3:00 p.m.

The 23rd entry on the floor administration narcotic page indicated one dose of oxycodone was administered by the AP on May 26 at 3:00 p.m.

The resident's EMAR indicated the AP did document administering one hydrocodone tablet on May 26, at 1:39 p.m.

The eighth entry on the central storage narcotic page indicated seven doses of oxycodone were put out on the floor by the AP on May 27. However, the amount remaining count went from 48 to 40, leaving one tablet unaccounted for.

The fourteenth entry on the central storage narcotic page indicated two doses of oxycodone were put out on the floor by the AP on June 1. However, the amount remaining count went from 35 to 32, leaving one tablet unaccounted for.

Example 2

A pharmacy delivery packing slip indicated the facility received 10 oxycodone 15 mg tablets May 6 signed by the AP.

The medication pass detail indicated the client had one oxycodone 15 mg tablet available every four hours as needed for pain.

The narcotic book page, unknown if it was from central storage or floor administration, indicated 10 oxycodone tablets were received on August 6.

The second entry on this page indicated the AP documented removing one oxycodone on May 6 at 6:00 p.m.

The EMAR did not indicate the dose was administered to the client.

The seventh entry on this page indicated the AP documented removing one oxycodone on May 10, at 8:00 a.m.

The EMAR did not indicate the dose was administered to the client.

Example 3

A pharmacy delivery packing slip indicated the facility received 84 oxycodone 10 mg tablets on June 30.

The EMAR indicated the scheduled oxycodone changed from one tablet every morning to two tablets every morning. At the same time the as needed dose of oxycodone changed from one tablet every six hours as needed to one time a day as needed.

The central supply narcotic book page indicated 56 oxycodone tablets were received on June 30. A sticker on the page indicated the client could have one oxycodone 10 mg tablet every morning and one table every six hours as needed, up to three tablets per day. The page included 25 entries.

The third entry on this page in the narcotic book indicated the AP documented removing one oxycodone on July 1 at 4:00 [p.m.].

The EMAR indicated the AP did not document administering this dose to the client. A second entry on the EMAR, on this date, indicated someone other than the AP administered a dose to the client at 7:49 p.m.

The fourth entry on this page indicated the AP documented removing one oxycodone on July 5 at 9:30 a.m.

The EMAR did not indicate the AP administered the dose to the client.

The tenth entry on this page indicated the AP documented removing one oxycodone on July 8 at 4:00 p.m.

The EMAR did not indicate the dose was administered to the client.

The twelfth entry on this page indicated the AP documented removing one oxycodone on July 11 at 3:30 p.m.

The EMAR did not indicate the dose was administered to the client.

The fourteenth entry on this page indicated the AP documented removing one oxycodone on July 12 at 3:30 p.m.

The EMAR did not indicate the dose was administered to the client.

The sixteenth entry on this page indicated the AP documented removing one oxycodone on July 13 at 8:00 a.m.

The EMAR did not indicate the dose was administered to the client.

The twenty-first entry on this page indicated the AP documented removing one oxycodone on July 15 at 4:15 [p.m.].

The EMAR did not indicate the dose was administered to the client.

The twenty-second entry on this page indicated the AP documented removing one oxycodone on July 17 at 5:00 p.m.

The EMAR did not indicate the dose was administered to the client. The EMAR indicated all the clients' medications were on hold.

The twenty-third entry on this page indicated the AP documented removing one oxycodone on July 18 at 9:00 a.m.

The EMAR did not indicate the dose was administered to the client. The EMAR indicated all the clients' medications were on hold.

The twenty-fourth entry on this page indicated the AP documented removing one oxycodone on July 21 at 2:00 p.m. The amount remaining was 24.

The EMAR did not indicate the dose was administered to the client. The EMAR had "X" in all the boxes for July 21.

The twenty-fifth, and final, entry on this page indicated the AP moved the 24 tablets to the floor, leaving the amount remaining was zero. The entry was not dated. The page had a diagonal line across the length of it.

Example 4

A pharmacy delivery packing slip indicated the facility received 84 oxycodone 10 mg tablets June 2.

The EMAR indicated the client had a scheduled dose of oxycodone every morning in addition to an as needed dose for pain. Both orders had changed in the amount or frequency through the month of June.

The central storage narcotic book page indicated 60 oxycodone tablets were received on June 2. The page had 27 entries.

The sixth entry on this page indicated the AP documented removing one oxycodone on June 9 at 8:00 [a.m.]

The EMAR did not indicate the dose was administered to the client.

The seventh entry on this page indicated the AP documented removing one oxycodone on June 10 at 9:00 [a.m.]

The EMAR did not indicate the dose was administered to the client.

The eighth entry on this page indicated the AP documented moving three or five [the handwritten number could be interpreted as a "3" or a "5"] oxycodone doses to the floor but did not include a date. The handwritten dates on the entry before is June 10 and the one after is June 12. However, the amount remaining went from 49 to 45, which did not equal the removal of three or five.

The fourteenth entry on this page indicated the AP documented moving an illegible amount of oxycodone doses to the floor on June 16. The amount remaining went from 38 to 32.

The seventeenth and eighteenth entry on this page indicated the AP documented removing one oxycodone on June 17 at 8:00 a.m. and one at 3:00 p.m.

The EMAR indicate one dose was administered to the client by the AP at 10:00 a.m. that day.

The nineteenth and twentieth entry on this page indicated the AP documented removing one oxycodone on June 20 at 10:00 [a.m.] and one at 4:00 p.m.

The EMAR indicate one dose was administered to the client by the AP at 4:45 p.m. that day.

The twenty-first entry on this page indicated the AP documented removing one oxycodone on June 21 at 10:00 [a.m.]

The EMAR did not indicate the dose was administered to the client.

The twenty-second entry on this page indicated the AP documented removing one oxycodone on June 22 at 10:00 [a.m.]

The EMAR did not indicate the dose was administered to the client.

The twenty-fifth entry on this page indicated the AP documented removing one oxycodone on June 24 at 8:00 a.m.

The EMAR did not indicate the dose was administered to the client. The EMAR indicated the clients' oxycodone was on hold on July 24.

The twenty-eighth entry on this page indicated the AP documented removing one oxycodone on June 29 at 11:00 [a.m.]. The amount remaining was 15.

The EMAR did not indicate the dose was administered to the client.

The last item documented on the page was the handwritten word "removed". There was no date and no signature on the line with the word. The Disposition of Unused Drug section at the bottom was blank.

Client #8

Example 1

A pharmacy delivery packing slip indicated the facility received 24 oxycodone 5 mg tablets on March 10.

The floor administration narcotic book page indicated 22 oxycodone tablets were received on March 10. A sticker on the page indicated the client could have one oxycodone tablet every four hours as needed for pain. The narcotic book page had 14 administration entries accounting for 14 of the 24 oxycodone tablets delivered from the pharmacy.

The fourth entry on this page indicated the count was corrected from 19 to 18. There was no date or signatures.

The fifth entry on this page indicated the AP documented removing one oxycodone on March 23 at 11:00 [a.m.]

The EMAR indicated the client did not receive any doses of oxycodone in March.

The sixth entry on this page indicated the AP documented removing one oxycodone on April 7 at 8:00 a.m. However, in the amount remaining column there were multiple scribble marks, and it was difficult to determine the number written as amount remaining.

The seventh entry on this page indicated the AP documented removing one oxycodone on April 28 at 9:45 a.m. The amount remaining column had a scribbled-out area and had 11 or 12 as the remaining amount, both numbers were written over each other.

The EMAR indicated the client did not receive any doses of oxycodone in April.

Client #10

Example 1

A pharmacy delivery packing slip indicated the facility received 120 Diazepam 2 mg tablets (valium) on March 1.

The central supply narcotic book page indicated 60 valium tablets were received on March 2. The page indicated the client could have two valium tablets every twice a day. The narcotic book page had two entries on the page.

The first entry indicated the AP put 30 tablets on the floor on March 7, and the amount remaining was 30.

The second entry indicated the AP destroyed 30 tablets on March 14 and the amount remaining was 0.

The page had a diagonal line through it. The bottom part of the page labeled Disposition of Unused Drug was blank.

The licensee Controlled Substance policy indicated narcotics in central storage, medication carts or cabinets will be counted at random by licensed staff at least weekly. When possible two licensed staff will verify the count in all areas.

The licensee's Disposition of Medication policy indicated upon discharge, medications given to the resident or the resident's responsible person will be documented by staff on the Disposition of Medication in the resident's record. The documentation would include the name of the person to whom the medication was given, the time and date, the name and amount of each medication. The disposition must also be documented on the disposition form and signed by the nurse and the resident or resident's responsible person. The policy further indicated all medication remaining after death, discharge, discontinued, or expired must be destroyed by the nurse.

Regarding controlled substances, the same document indicated controlled substances will be destroyed by a nurse with one other staff member as a witness. The policy also indicated the Disposition / Disposal Record must be signed by the nurse and another individual when controlled substances are disposed of and the disposition of controlled substances will also be documented in the narcotic log and signed by the nurse and a witness.

During the interview with the manager, the manager stated the licensee management team was made aware of concerns involving the AP's poor medications management skills. The concern included the AP signing out medications under other staff members names and asking other staff for narcotics. The manager stated this concern came about when the AP was working at a different licensee managed by the company. The management team reviewed documents from this licensee during the time of the AP's employment and found multiple

concerns. The manager stated there were concerns with the number of missing documents when narcotic medications were received from the pharmacy, with how many daily doses of narcotics the AP administered, and the lack of documentation for destroyed narcotics. The manager further stated it was not the AP's job duty to administer medications unless there was an emergency with another staff member or if there was shortage in staff.

During the interview with the AP, the AP stated if a resident came to the office and asked for a medication, the medication could be given from there. The AP stated when medications had to be destroyed two staff members did that together and one of those staff members had to be a nurse, which was usually the LPN. The AP did not recall what the policy was regarding errors in counting controlled substances. The AP stated the task of administering medications, while not part of her daily routine, did at times occur. When asked if the AP could explain why she gave narcotics multiple days in a row the AP stated she was not sure, but she was probably helping staff catch up. The AP also stated staff were not very good with "as needed" medications because they were not able to assess residents' pain very well. The investigator reviewed multiple occasions in which the AP had administered medications out of central storage, the AP stated she had to administer out of there because sometimes she was the only nurse-on-duty. The AP denied taking any narcotics for personal use.

In conclusion, the Minnesota Department of Health determined financial exploitation was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

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

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9

"Financial exploitation" means:

(b) In the absence of legal authority, a person:

- (1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
- (2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
- (3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
- (4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult or Family/Responsible Party interviewed: Yes, with the exception of client #7, client #13, and client #15 for whom the attempts were not successful.

Alleged Perpetrator interviewed: Yes.

Action taken by facility: The facility cooperated with the investigation.

Action taken by the Minnesota Department of Health:

The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

You may also call 651-201-4200 to receive a copy via mail or email

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Minneapolis City Attorney
Minneapolis Police Department
Minnesota Board of Nursing
Minnesota Board of Executives for Long Term Services and Supports
Drug Enforcement Administration

RECONSIDERATION REQUESTED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H03383	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/16/2025
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HOME HEALTH CARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 901 4TH AVENUE NORTH MINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** HOME CARE PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL033831355C / #HL033836862M On December 5, 2024 through January 16, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. The following correction order is issued/orders are issued for #HL033836862M, tag identification 0325.	0 000	Home Care Provider 144A. Minnesota Department of Health is documenting the State 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 evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H03383	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/16/2025
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HOME HEALTH CARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 901 4TH AVENUE NORTH MINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Continued From page 1	0 000	SUBDIVISION 11 (b)(1)(2).		
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act This MN Requirement is not met as evidenced by: The facility failed to ensure six of 18 client(s) reviewed (C1, C4, C5, C7, C8, and C10) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	0 325			

RECONSIDERATION REQUESTED