

Office of Health Facility Complaints

Investigative Public Report

Maltreatment Report #: HL23224005M
Compliance #: HL23224006C

Date Concluded: November 4, 2020

Name, Address, and County of Licensee

Investigated:

Minnesota Greenleaf
1006 Greenwood Street
Thief River Falls, MN 56701
Pennington County

Facility Type: Home Care Provider

Investigator's Name:

Michele R. Larson, RN Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:

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.

Allegation:

It is alleged: The alleged perpetrator (AP) financially exploited the client when the AP took money from the client.

Investigative Findings and Conclusion:

Financial exploitation was substantiated. The alleged perpetrator was responsible for the maltreatment. The AP took \$200 from the client's petty cash fund for personal use.

The investigation included interviews with facility staff members, including administrative staff. The investigation also included interview with the client's social worker and the client's family member. The investigation included review of the client's medical record, facility's internal investigation file, and facility policies.

The client received comprehensive home care services and her diagnoses included psychoses. She received services for behavior management, medication management, bathing, meals, and homemaking. The client was able to make her needs known, however, she was vulnerable to

financial exploitation due to her inability to manage her finances and required assistance from the facility to manage her money.

One day the client's social worker received a call from the facility's former assistant administrator informing him the AP took \$200.00 from the client's petty cash at an unknown date. She said the AP used the money for a personal vacation. The social worker said she was not sure the AP repaid the \$200.00 back to the client. The social worker said the former assistant administrator and the AP were in charge of counting petty cash and said the AP chose to take the \$200.00 from the client's petty cash because the client never took money out of her petty cash fund. The client relied on the facility to manage her cash. The client had no family who lived close by, except a grandson who lived over one hour away from the client.

The facility conducted an internal investigation, and after the investigation was concluded, the facility deducted \$200.00 from the AP's last paycheck and deposited the money back into the client's petty cash account.

During an interview, the former assistant administrator said she and the AP managed the facility and client's petty cash. She said one day, while counting petty cash, she saw a sticky note with the AP's signature on it, indicating she had borrowed \$200.00 from the client and would repay the client at the next payday. She said she repeatedly asked the AP to return the \$200.00 to the client. She said after the AP ended employment, she alerted management the AP took \$200.00 from the client and never repaid it.

During an interview, the activities director said one day after counting petty cash, the former assistant administrator pointed to a sticky note inside the client's petty cash and said to her the AP took \$200.00 from the client's petty cash fund and never returned the money. She said the client's petty cash and facility's petty cash were in a locked storage closet inside the business office. She said the facility and client petty cash were in clearly marked boxes in two separate file cabinets. She said the facility petty cash box was in a locked metal box, and the client's petty cash was stored in an unlocked recipe box. She said three people had access to petty cash: herself, the former assistant administrator, and the AP. She said she was unaware of a policy allowing staff to borrow money from petty cash, and said it was the first time she heard about staff taking money from petty cash.

During an interview, the AP said the \$200.00 she took was from the facility's petty cash fund, not the client's. The AP said she placed a sticky note inside the facility petty cash box, but somehow the note was found inside the client's petty cash. She said the money was used as a personal loan, and even though the facility had no policy indicating petty cash could be used for personal loans, she and the former assistant administrator often borrowed money from petty cash to give out as loans for staff who were "down and out." The AP said she was alone when she took the \$200.00, but said she told the assistant administrator that same day. Later in the interview the AP said after reconciling facility petty cash they realized it came out of the client's petty cash. The AP said she never told management.

Review of the AP's records indicated the AP previously admitted to a misdemeanor issued dishonored check.

In conclusion, financial exploitation was substantiated.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9

"Financial exploitation" means:

(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:

(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or

(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.

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

(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

Vulnerable Adult interviewed: No, unable to interview due to cognitive status.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The AP is no longer employed at the facility. The facility conducted an internal investigation and returned the \$200.00 back to the client.

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
Minnesota Department of Human Services - Licensing
Minnesota Board of Nursing
Pennington County Attorney
Thief River Falls City Attorney
Thief River Falls Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H23224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/28/2020
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NAME OF PROVIDER OR SUPPLIER MINNESOTA GREENLEAF	STREET ADDRESS, CITY, STATE, ZIP CODE 4445 2ND AVE SOUTH FARGO, ND 58103
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>HOME CARE PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>On August 28, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL23224006C/#HL23224005M. At the time of the survey, there were 52 clients receiving services under the comprehensive license.</p> <p>The following correction orders are issued for #HL23224006C/#HL23224005M, tag identification 325, 800, 805, 810, 815, and 2015.</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2)</p>	
0 325	<p>144A.44, Subd. 1(a)(14) Free From Maltreatment</p> <p>Subdivision 1.Statement of rights. (a) A client who</p>	0 325		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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0 325	<p>Continued From page 1</p> <p>receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act;</p> <p>This MN Requirement is not met as evidenced by: Based on interviews, and document review, the facility failed to ensure one of three clients reviewed (C1) was free from maltreatment. C1 was financially exploited.</p> <p>Findings include:</p> <p>On November 4, 2020, the Minnesota Department of Health (MDH) issued a determination financial exploitation occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.</p>	0 325	Plan of correction is not required for tag 0325, please refer to the public maltreatment report for details.	
0 800 SS=D	<p>144A.479, Subd. 5 Handling of Client's Finances/Property</p> <p>Subd. 5. Handling of client's finances and property. (a) A home care provider may assist clients with household budgeting, including paying bills and purchasing household goods, but may not otherwise manage a client's property. A home care provider must provide a client with receipts for all transactions and purchases paid</p>	0 800		

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0 800	<p>Continued From page 2</p> <p>with the client's funds. When receipts are not available, the transaction or purchase must be documented. A home care provider must maintain records of all such transactions.</p> <p>(b) A home care provider or staff may not borrow a client's funds or personal or real property, nor in any way convert a client's property to the home care provider's or staff's possession.</p> <p>(c) Nothing in this section precludes a home care provider or staff from accepting gifts of minimal value, or precludes the acceptance of donations or bequests made to a home care provider that are exempt from income tax under section 501(c) of the Internal Revenue Code of 1986.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure one of three clients (C1) reviewed, was protected from financial exploitation when a staff member took \$200.00 from C1's petty cash account.</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 client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>Findings Include:</p> <p>C1's medical record was reviewed. C1's medical diagnoses included, psychoses, and chronic venous insufficiency. C1 service plan dated, April 15, 2020, indicated C1 required assistance with</p>	0 800	<p>The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state 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>Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with</p>	

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0 800	<p>Continued From page 3</p> <p>bathing, meals, medication and behavior management. C1 required the use of a wheelchair for ambulation.</p> <p>Review of the licensee's internal investigation documents indicated on February 14, 2020, the licensee deducted \$200.00 from director of nursing (DON)-D's paycheck. On June 17, 2020, the licensee interviewed DON-D, who confirmed she took \$200.00 from C1's account to pay the licensee's petty cash account. DON-D said unlicensed personnel (ULP)-C told her C1's \$200.00 was never returned to C1's petty cash account.</p> <p>During an interview on September 9, 2020, at 2:37 p.m., social worker (SW)-A said on June 8, 2020, he received a phone call from ULP-C saying DON-D took money from C1's petty cash account. ULP-C said DON-D never repaid the \$200.00 back to C1's petty cash.</p> <p>During an interview on September 11, 2020, at 10:20 a.m., family member (FM)-B said the licensee never told him about C1's money being stolen, even after regular visits with C1. FM-B said SW-A told him two employees from the licensee were involved; ULP-C who knew DON-D took took \$200.00 and never reported it to licensee, and DON-D, the staff member who took the \$200.00. FM-B said SW-A was unsure if the \$200 was returned to C1's petty cash. FM-B said C1 had saved up a significant amount of money in her petty cash. FM-B said C1 had access to her petty cash but rarely used it.</p> <p>During an interview on September 11, 2020, at 2:00 p.m., ULP-C said DON-D took \$200.00 from C1's petty cash for a personal vacation, but was unsure of the exact day and month. ULP-C said</p>	0 800	<p>the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction."</p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).</p>	

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0 800	<p>Continued From page 4</p> <p>while reconciling C1's petty cash she noticed a sticky note written by DON-D. ULP-C said the sticky note indicated DON-D took \$200.00 from C1 and would repay the \$200.00 back to C1's petty cash. ULP-C said she never recalled DON-D telling her she took the money from C1. ULP-C said she confronted DON-D, asking her to pay back the \$200.00. ULP-C said, "it put me in a difficult position because she was my boss." ULP-C said in April of 2020 after DON-D was terminated; she told the licensee about DON-D taking money from C1. ULP-C said three people had access to petty cash; ULP-C, ULP-D, and ULP-E. ULP-C said the licensee occasionally borrowed money from the licensee petty cash fund for staff who needed money before payday. ULP-C said clients who requested money from their personal petty cash, signed a receipt book indicating they received their money. The licensee recorded the transactions on a computer spreadsheet. ULP-C said she had no idea why ULP-D took \$200.00 from C1's petty cash instead of the licensee's.</p> <p>During an interview on September 18, 2020, at 1:02 p.m., ULP-E said in February or March of 2020 while counting petty cash, with ULP-C; ULP-C pointed to a yellow sticky note inside clients' petty cash box, saying, "yeah, and DON-D never even paid this back." ULP-E said the note indicated DON-D took money from C1's petty cash and would pay it back on payday. ULP-E said she, ULP-C, and DON-D were the only staff who accessed licensee's and client's petty cash. ULP-E said both petty cash boxes were stored in a locked storage closet inside the business office. The licensee's petty cash box was kept in a locked metal box in a file cabinet and client's petty cash box was stored in an unlocked box in a separate file cabinet. ULP-E said the door was</p>	0 800		
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0 800	<p>Continued From page 5</p> <p>always locked when management was not in the office. ULP-E said the licensee never retrained staff after C1's petty cash was taken. ULP-E said she was unaware of a policy indicating staff could borrow money out of petty cash.</p> <p>The licensee policy titled "Storage of Valuables and Money", updated May 8, 2018, indicated clients' petty cash were kept in the licensee safe. Withdrawal of client's petty cash was logged and occurred only at the request from the client or their power of attorney, (POA).</p> <p>The licensee policy titled "Code of Conduct", updated May 5, 2016, indicated staff members were to uphold the licensee's policies, procedures, and values and to act in accordance to the highest standards of professional integrity.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	0 800		
0 805 SS=D	<p>144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors</p> <p>Subd. 6.Reporting maltreatment of vulnerable adults and minors. (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care provider must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the</p>	0 805	The Minnesota Department of Health	

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0 805	<p>Continued From page 6</p> <p>licensee failed to report suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) when one of three clients (C1) reviewed had been financially exploited by a licensee employee.</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 client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>Findings include:</p> <p>Review of the MAARC report dated June 9, 2020, indicated the estimated date and time of most recent occurrence was January 15, 2020 at 12:00 p.m. Description of the incident indicated the former director of nursing (DON)-D took money from the client's petty cash for a personal vacation. The report further indicated the licensee knew about the maltreatment two months after the incident, but failed to file a MAARC report.</p> <p>C1's medical record was reviewed. C1's medical diagnoses included, psychoses, and chronic venous insufficiency. C1's service plan dated, April 15, 2020, indicated C1 required assistance with bathing, meals, medication and behavior management. C1 required the use of a wheelchair for ambulation.</p> <p>Review of the licensee's internal investigation documents indicated on February 14, 2020, the licensee deducted \$200.00 from director of nursing (DON)-D's paycheck. On June 17, 2020, the licensee interviewed DON-D, who confirmed</p>	0 805	<p>documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state 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>Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction."</p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11(b).</p>	

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0 805	<p>Continued From page 7</p> <p>she took \$200.00 from C1's account to pay the licensee's petty cash account. DON-D said ULP-C told her C1's \$200.00 was never returned to C1's petty cash account.</p> <p>During an interview on September 9, 2020, at 2:37 p.m., social worker (SW)-A said unlicensed personnel (ULP)-C called him in June of 2020 saying she was terminated from the licensee. During the phone call, ULP-C told him in 2019 DON-D took \$200 from C1's petty cash account. ULP-C told SW-A she was unsure the \$200 was returned to C1's petty cash. SW-A said the licensee never told him money had been taken from C1's petty cash.</p> <p>During an interview on September 11, 2020 at 2:00 p.m., ULP-C said in April of 2020, she alerted the licensee that DON-D took \$200 from C1's petty cash. ULP-C said she told the licensee \$200 needed to be deducted from DON-D's last paycheck to repay C1's petty cash. ULP-C said she was unsure if the \$200.00 was put back into C1's account.</p> <p>During an interview on September 18, 2020, at 1:02 p.m., ULP-E said in February or March of 2020, ULP-C told her DON-D took \$200 from C1's petty cash and never repaid it. ULP-E said she received vulnerable adult training when she was hired but did not receive any ongoing training or retraining. ULP-E said if suspected a client was being maltreated she would report it to the licensee.</p> <p>The licensee policy titled, "Mandated Reporting," updated March 18, 2019, indicated suspected maltreatment was to be reported to the licensee within 24 hours. Investigations were to be conducted immediately.</p>	0 805		

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0 805	Continued From page 8 TIME PERIOD FOR CORRECTION: Seven (7) days.	0 805		
0 810 SS=D	<p>144A.479, Subd. 6(b) Individual Abuse Prevention Plan</p> <p>(b) Each home care provider must develop and implement an individual abuse prevention plan for each vulnerable minor or adult for whom home care services are provided by a home care provider. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update an individual abuse prevention plan, (IAPP), for one of three clients (C1) reviewed after C1 was financially exploited.</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 client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>Findings include:</p>	0 810	<p>The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as</p>	

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0 810	<p>Continued From page 9</p> <p>C1's medical record was reviewed. C1's medical diagnoses included, psychoses, and chronic venous insufficiency. C1's service plan dated, April 15, 2020, indicated C1 required assistance with bathing, meals, medication and behavior management. C1 required the use of a wheelchair for ambulation.</p> <p>Review of the licensee's internal investigation documents indicated on February 14, 2020, the licensee deducted \$200.00 from director of nursings (DON)-D's paycheck. On June 17, 2020, the licensee interviewed DON-D, who confirmed she took \$200.00 from C1's account to pay the licensee's petty cash account. DON-D said unlicensed personnel (ULP)-C told her C1's \$200.00 was never returned to C1's petty cash account.</p> <p>C1's IAPP dated August 15, 2020, indicated C1 was assessed as vulnerable for unable to manage finances with needed intervention of family or responsible person to assist and manage finances. C1 was assessed as vulnerable in orientation to person, place, and time with needed intervention in remaining safe in her surroundings with family involvement. C1 was not assessed as vulnerable in unable to report abuse, neglect, or concerns. A box with the following statement, "client does not appear to have any areas of vulnerability requiring interventions at this time," was unchecked. The IAPP failed to included interventions to prevent theft of C1's petty cash.</p> <p>During an interview on September 11, 2020, at 2:00 p.m., ULP-C said DON-D took \$200.00 from C1's petty cash for a personal vacation, but was unsure of the exact day and month. ULP-C said</p>	0 810	<p>evidenced by." Following the surveyors ' findings is the Time Period for Correction.</p> <p>Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction."</p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).</p>	

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0 810	<p>Continued From page 10</p> <p>while reconciling C1's petty cash she noticed a sticky note written by DON-D. ULP-C said the sticky note indicated DON-D took \$200.00 from C1 and would repay the \$200.00 back to C1's petty cash. ULP-C said she never recalled DON-D telling her she took money from C1. ULP-C said she confronted DON-D, asking her to pay back the \$200.00. ULP-C said, "it put me in a difficult position because she was my boss." ULP-C said in April of 2020 after DON-D was terminated; she told the licensee about DON-D taking money from C1. ULP-C said three people had access to petty cash; ULP-C, DON-D, and ULP-E. ULP-C said the licensee occasionally borrowed money from the licensee petty cash fund for staff who needed money before payday. ULP-C said clients who requested money from their personal petty cash, signed a receipt book indicating they received their money. The licensee recorded the transactions on a computer spreadsheet. ULP-C said she had no idea why DON-D took \$200.00 from C1's petty cash instead of the licensee's.</p> <p>During an interview on September 18, 2020, at 1:00 p.m., ULP-E said clients and licensee's petty cash were kept in a storage closet inside the business office. ULP-E said the client's petty cash was kept in an unlocked recipe box in a file cabinet. ULP-E said licensee petty cash was kept in a locked metal box in a different file cabinet.</p> <p>The licensee policy titled "Abuse Prevention," updated April 5, 2016, indicated the licensee provided a safe environment for clients and allegations of client abuse would be resolved by involving all parties necessary to determine the appropriate outcome.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7)</p>	0 810		

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0 810	Continued From page 11 days.	0 810		
0 815 SS=E	<p>144A.479, Subd. 7 Employee Records</p> <p>Subd. 7.Employee records. The home care provider must maintain current records of each paid employee, regularly scheduled volunteers providing home care services, and of each individual contractor providing home care services. The records must include the following information:</p> <p>(1) evidence of current professional licensure, registration, or certification, if licensure, registration, or certification is required by this statute or other rules;</p> <p>(2) records of orientation, required annual training and infection control training, and competency evaluations;</p> <p>(3) current job description, including qualifications, responsibilities, and identification of staff providing supervision;</p> <p>(4) documentation of annual performance reviews which identify areas of improvement needed and training needs;</p> <p>(5) for individuals providing home care services, verification that any health screenings required by infection control programs established under section 144A.4798 have taken place and the dates of those screenings; and</p> <p>(6) documentation of the background study as required under section 144.057.</p> <p>Each employee record must be retained for at</p>	0 815		

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0 815	<p>Continued From page 12</p> <p>least three years after a paid employee, home care volunteer, or contractor ceases to be employed by or under contract with the home care provider. If a home care provider ceases operation, employee records must be maintained for three years.</p> <p>This MN Requirement is not met as evidenced by: Based on record review, the licensee failed to provide back ground checks for two of five unlicensed personnel (ULP)-C, and former director of nursing (DON)-D records reviewed.</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 client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>Findings Include:</p> <p>ULP-C's personnel file was reviewed on September 3, 2020 and failed to include a cleared background study in ULP-C's file.</p> <p>DON-D's personnel file was reviewed on September 3, 2020 and failed to included a cleared background study in DON-D's file.</p> <p>An email to the licensee's administrator dated August 31, 2020, at 12:19 p.m., the surveyor requested background checks for five employees, ULP-C, DON-D, ULP-E, ULP-F, and ULP-G.</p> <p>An email from the licensee administrator, dated September 2, 2020, at 5:53 p.m., contained</p>	0 815	<p>The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state 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>Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction."</p> <p>The letter in the left column is used for</p>	

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0 815	Continued From page 13 ULP-E, ULP-F, and ULP-G's background studies. An email dated September 15, 2020, at 4:41 p.m., the surveyor emailed the licensee's administrator a second time requesting ULP-C and DON-D's background studies. An email dated September 15, 2020, at 4:52 p.m., the licensee administrator said the background studies were sent. No further documentation was provided by the licensee. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 815	tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
02015 SS=D	626.557, Subd. 3 Timing of Report Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined	02015		

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02015	<p>Continued From page 14</p> <p>in section 626.5572, subdivision 21, paragraph (a), clause (4).</p> <p>(b) A person not required to report under the provisions of this section may voluntarily report as described above.</p> <p>(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.</p> <p>(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.</p> <p>(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report suspected maltreatment</p>	02015	The Minnesota Department of Health documents the State Licensing Correction	

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02015	<p>Continued From page 15</p> <p>to the Minnesota Adult Abuse Reporting Center (MAARC) when one of three client (C1) reviewed had been financially exploited by a licensee employee.</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 client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>Findings include:</p> <p>Review of the MAARC report dated June 9, 2020, indicated the estimated date and time of most recent occurrence was January 15, 2020 at 12:00 p.m. Description of the incident indicated former director of nursing (DON)-D took money from the client's petty cash for a personal vacation. The report further indicated the licensee knew about the maltreatment two months after the incident, but failed to file a MAARC report.</p> <p>C1's medical record was reviewed. C1's medical diagnoses included, psychoses, and chronic venous insufficiency. C1's service plan dated, April 15, 2020, indicated C1 required assistance with bathing, meals, medication and behavior management. C1 required the use of a wheelchair for ambulation.</p> <p>Review of the licensee's internal investigation documents indicated on February 14, 2020, the licensee deducted \$200.00 from DON-D's paycheck. On June 17, 2020, the licensee interviewed DON-D, who confirmed she took \$200.00 from C1's account to pay the licensee's</p>	02015	<p>Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state 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>Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction."</p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).</p>	

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02015	<p>Continued From page 16</p> <p>petty cash account. DON-D said unlicensed personnel (ULP)-C told her C1's \$200.00 was never returned to C1's petty cash account.</p> <p>During an interview on September 9, 2020, at 2:37 p.m., social worker (SW)-A said ULP-C called him in June of 2020 saying she was terminated from the licensee. During the phone call, ULP-C told him in 2019 DON-D took \$200 from C1's petty cash account. ULP-C told SW-A she was unsure the \$200 was returned to C1's petty cash. SW-A said the licensee never told him money had been taken from C1's petty cash.</p> <p>During an interview on September 11, 2020 at 2:00 p.m., ULP-C said in April of 2020, she alerted the licensee that ULP-D took \$200 from C1's petty cash. ULP-C said she told the licensee \$200 needed to be deducted from DON-D's last paycheck to repay C1's petty cash. ULP-C said she was unsure if the \$200.00 was put back into C1's account.</p> <p>During an interview on September 18, 2020, at 1:02 p.m., ULP-E said in February or March of 2020, ULP-C told her DON-D took \$200 from C1's petty cash and never repaid it. ULP-E said she received vulnerable adult training when she was hired but did not receive any ongoing training or retraining. ULP-E said if suspected a client was being maltreated she would report it to the licensee.</p> <p>The licensee policy titled, "Mandated Reporting," updated March 18, 2019, indicated suspected maltreatment was to be reported to the licensee within 24 hours. Investigations were to be conducted immediately.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7)</p>	02015		

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02015	Continued From page 17 days.	02015		