MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Home Care Services	HL23595001	July 28, 2016
Facility Address:	**Time of Visit:**	**Date Concluded:**
201 S County Road 5	10:30 a.m. - 4:30 p.m.	September 19, 2016
Facility City:	**Investigator's Name and Title:**	
Springfield	Darin Hatch, Special Investigator Arthur Biah, RN, Special Investigator	

State:	ZIP:	County:
Minnesota	56087	Brown

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that two clients were financially exploited when the alleged perpetrator (AP) took the client's narcotic medications.

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, financial exploitation is substantiated. The alleged perpetrator (AP) took narcotic medications from two clients on several occasions.

Client #1 received services from the home care provider for daily wellness checks, oxygen tank service, assistance with compression stockings, and weekly blood pressure checks according to the client's service agreement. Client #1 had a physician's order for several strengths of oxycodone (an opioid narcotic) to be taken as needed multiple times per day.

Client #2 received services from the home care provider for transfer assistance when bathing according to the client's service agreement. Client #2 had a physician's order for hydrocodone/APAP (an opioid narcotic).

Neither client received medication management service from the home care provider.

A family member reported they suspected a staff member was taking medications from both clients. The housing director sat in Client #1's apartment while they were out of the apartment at supper. There was a medication bottle on a table in the living room with medication inside. S/he observed the AP knock on the door, enter the apartment, pour medications from Client #1's medication bottle, and leave the apartment. The staff checked the pill bottle and said it was empty. S/he notified the police. Police came to the facility and the AP admitted s/he took pills from the clients a few times. Police searched the AP and discovered eight pills belonging to Client #1.

Interviews with clients revealed Client #2 was missing 14 hydrocodone/APAP tablets from the pill bottle

that was stored in the medicine cabinet in the bathroom. Client #1 was missing over 20 tablets from the pill bottles that were stored on a table in the living room.

A police report was reviewed. Police searched the AP and interviewed him/her. Police discovered 8 oxycodone tablets belonging to Client #1 in the AP's pocket. The AP admitted to police s/he took pills from both clients. Police forwarded their findings to the county attorney for possible criminal charges. Attempts to interview the AP were unsuccessful.

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☐ Neglect ☒ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

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

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

The home care provider had policies in place to prevent financial exploitation. The AP's personnel file showed the AP's acknowledgment of receiving the "Employee Handbook" which indicated any theft was unacceptable in the workplace and was grounds for involuntary termination. The AP's personnel file showed the AP received training in regards to the policies in place.

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

Compliance:

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

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

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

State licensing orders were issued: ☒ Yes ☐ No

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

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 9 - Financial exploitation

"Financial exploitation" means:

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

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

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

- ☒ Medical Records
- ☒ Assessments
- ☒ Physician Orders
- ☒ Care Plan Records
- ☒ ADL (Activities of Daily Living) Flow Sheets
- ☒ Service Plan

Other pertinent medical records:

- ☒ Police Report

Additional facility records:

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

Number of additional resident(s) reviewed: 0

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

Specify: No additional records selected

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

◉ Yes ○ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact complainant, attempts were made on:

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

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

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

◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: 13

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 4

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

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

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:
08/02/2016	12:38 p.m.	08/04/2016	8:47 a.m.	08/08/2016	9:17 a.m.

If unable to contact was subpoena issued: ◉ Yes, date subpoena was issued 08/08/2016 ○ No

Were contacts made with any of the following:

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

Observations were conducted related to:

- ☒ Cleanliness
- ☒ Dignity/Privacy Issues
- ☒ Safety Issues
- ☒ Meals
- ☒ Facility Tour

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

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

Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Springfield Police Department

Brown County Attorney

Springfield City Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H23595	A. BUILDING: _____ B. WING _____	C 08/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME CARE SERVICES	201 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087

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0 000	Initial Comments *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, these correction orders are issued pursuant to a survey. 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. INITIAL COMMENTS: On July 28, 2016, a complaint investigation was initiated to investigate complaint #HL23595001. At the time of the survey, there were 31 clients that were receiving services under the comprehensive license. The following correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.	
0 325 SS=D	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act;	0 325		

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0 325	Continued From page 1 This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to ensure that two of two clients (C1) and (C2) reviewed were free from maltreatment when the clients were financially exploited by a staff when she took medications from both clients on different occasions for her own personal use. This resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death) and is 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 that a situation has occurred only occasionally.) The findings include: C1's file was reviewed. C1 received services from the licensee for daily wellness checks, oxygen tank service, assistance with compression stockings, and weekly blood pressure checks according to a service agreement dated April 9, 2014. C1 did not receive medication management service from the provider. C1 kept his medications on a table in his living room. C1 had a physician's order dated April 4, 2016 for Oxycodone 5 milligrams (mg) 1-2 tablets as needed every 4-6 hours, April 7, 2016 for Oxycodone 5mg 1 tablet as needed every 3 hours, April 7, 2016 for Oxycontin 15mg 1 tablet every 12 hours, and April 12, 2016 Oxycodone 5mg 1 tablet as needed every 3 hours. C2's file was reviewed. C2 received services from the licensee for transfer assistance when	0 325		

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0 325	Continued From page 2 bathing according to a service agreement dated April 9, 2014. C2 did not receive medication management service from the provider. C2 kept her medications in the medicine cabinet in the bathroom. C2 had a physician's order dated April 15, 2016 for Hydrocodone/APAP 5/325mg, 1 tablet twice daily as needed. Interview with housing director (HD)-C on July 28, 2016 at 2:50 p.m. revealed family member (F)-D reported to HD-C on April 20 and April 22, 2016 that F-D suspected a staff member was taking medications from C1 and C2 because they were missing medications. HD-C sat in the apartment for C1 and C2 on April 22, 2016 while C1 and C2 were out of the apartment at supper and observed unlicensed professional (ULP)-E knock on the door, enter the apartment, pour medications from C1's medication bottle that was on the table in the living room, and leave the apartment. HD-C checked the pill bottle and said it was empty. HD-C said she checked the bottle when she entered the apartment and the bottle previously contained medications belonging to C1 prior to ULP-E taking the medications. HD-C said she notified the police. HD-C said police came to the facility and ULP-E admitted she took pills from clients a few times. She said police searched ULP-E and discovered eight pills belonging to C1. Interview with registered nurse (RN)-B on July 28, 2016 at 1:06 p.m. revealed she was made aware the week following April 14, 2016 by F-D that F-D suspected medications belonging to C1 and C2 were stolen. RN-B revealed she was also made aware ULP-E was suspected and admitted to taking medications from C1 and C2 on April 22, 2016. Interview with C1 and C2 on July 28, 2016 at 2:20	0 325		

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0 325	Continued From page 3 p.m. revealed C2 said she was missing 14 Hydrocodone/APAP 5/325 mg tablets from her pill bottle that she stored in the medicine cabinet in the bathroom sometime between April 15-20, 2016. She told F-D she was missing the medications on April 20, 2016. C1 said he was missing over 20 Oxycontin and Oxycodone tablets from his pill bottles that he stored on a table in his living room sometime between April 7-22, 2016. He said he told F-D on April 7 and April 22, 2016. Interview with F-D on August 2, 2016 at 3:11 p.m. revealed C1 made her aware he was missing 15 Oxycontin 15mg tablets on April 7 and 5 Oxycontin 15mg and 3 Oxycodone 5mg tablets on April 22, 2016. C2 made her aware she was missing 14 Hydrocodone 5/325 mg tablets on April 20, 2016. F-D said she made the licensee aware of missing medications for C1 and C2 on April 20 and April 22, 2016. F-D said during interview C1 was missing: 20 Oxycontin 15mg tablets, 3 Oxycodone 5mg tablets and C2 was missing 14 Hydrocodone 5/325mg tablets. F-D said the medications for C1 and C2 were taken between April 7-22, 2016. Document review revealed a police report dated April 22, 2016 which indicated police were called to the facility because HD-C suspected ULP-E had taken medication from C1 and C2. The report indicated HD-C had observed ULP-E take medications from C1's pill bottle located on C1's table in C1's apartment when C1 and C2 were at supper on April 22, 2016. Police searched ULP-E and interviewed her. Police discovered 5 Oxycontin 15mg and 3 Oxycodone 5mg tablets belonging to C1 in ULP-E's pocket. ULP-E admitted to police she took the pills from C1. Police forwarded their findings to the county	0 325		

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0 325	Continued From page 4 attorney for formal charging. Document review of C1 and C2's files revealed both clients were offered the Minnesota Home Care Bills of Rights by the licensee and signed the documents on April 9, 2014. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 325		
0 805 SS=D	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that incidents of suspected financial exploitation were reported immediately to the state agency for two of two clients (C1) and (C2) reviewed. This practice resulted in a level 2 violation (a violation that did not harm the client's health or safety but had the potential to have harmed a client's health or safety) and is 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 that a situation has occurred only occasionally.) The findings include: C1's file was reviewed. C1 received services from the licensee for daily wellness checks, oxygen tank service, assistance with compression stockings, and weekly blood pressure checks according to a service agreement dated April 9, 2014. C1 did not receive medication management service from the	0 805		

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0 805	Continued From page 5 provider. C1 kept his medications on a table in his living room. C1 had a physician's order dated April 4, 2016 for Oxycodone 5 milligrams (mg) 1-2 tablets as needed every 4-6 hours, April 7, 2016 for Oxycodone 5mg 1 tablet as needed every 3 hours, April 7, 2016 for Oxycontin 15mg 1 tablet every 12 hours, and April 12, 2016 Oxycodone 5mg 1 tablet as needed every 3 hours. C2's file was reviewed. C2 received services from the licensee for transfer assistance when bathing according to a service agreement dated April 9, 2014. C2 did not receive medication management service from the provider. C2 kept her medications in the medicine cabinet in the bathroom. C2 had a physician's order dated April 15, 2016 for Hydrocodone/APAP 5/325mg, 1 tablet twice daily as needed. Interview with housing director (HD)-C on July 28, 2016 at 2:50 p.m. revealed family member (F)-D reported to HD-C on April 20 and April 22, 2016 that F-D suspected a staff member was taking medications from C1 and C2 because they were missing medications. HD-C sat in the apartment for C1 and C2 on April 22, 2016 while C1 and C2 were out of the apartment at supper and observed unlicensed professional (ULP)-E knock on the door, enter the apartment, pour medications from C1's medication bottle that was on the table in the living room, and leave the apartment. HD-C checked the pill bottle and said it was empty. HD-C said she checked the bottle when she entered the apartment and the bottle previously contained medications belonging to C1 prior to ULP-E taking the medications. HD-C said she notified the police. HD-C said police came to the facility and ULP-E admitted she took pills from clients a few times. She said police searched	0 805		

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0 805	Continued From page 6 ULP-E and discovered eight pills belonging to C1. HD-C admitted she did not notify the state agency to report the suspected financial exploitation on April 20, 2016 nor the confirmed financial exploitation on April 22, 2016. Interview with registered nurse (RN)-B on July 28, 2016 at 1:06 p.m. revealed she was made aware the week following April 14, 2016 by F-D that F-D suspected medications belonging to C1 and C2 were stolen. RN-B revealed she was also made aware ULP-E was suspected and admitted to taking medications from C1 and C2 on April 22, 2016. RN-B admitted she did not notify the state agency to report the suspected financial exploitation when made aware the week following April 14, 2016 nor the confirmed financial exploitation on April 22, 2016. An undated policy titled "Vulnerable Adult Reporting" reads on page one "a report of suspected or witnessed maltreatment is to be made to the common entry point." In addition the policy reads on page one "all employees caring for Home Care Services clients MUST REPORT any suspected or witnessed incidents that appears to be suspected abuse, neglect. or financial exploitation and the Director or RN will make a report to the CEP as soon as possible." The policy states on page four "The Vulnerable Adult Act requires that the program submit a report of each reportable incident to the MAARC within 24 hours of notification." TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 805		

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02015	Continued From page 7	02015		
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 in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (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. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.	02015		

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02015	Continued From page 8 (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 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 agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that incidents of suspected financial exploitation were reported immediately to the state agency for two of two clients (C1) and (C2) reviewed. This practice resulted in a level 2 violation (a violation that did not harm the client's health or safety but had the potential to have harmed a client's health or safety) and is 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 that a situation has occurred only occasionally.) The findings include: C1's file was reviewed. C1 received services from the licensee for daily wellness checks, oxygen tank service, assistance with	02015		

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02015	Continued From page 9 compression stockings, and weekly blood pressure checks according to a service agreement dated April 9, 2014. C1 did not receive medication management service from the provider. C1 kept his medications on a table in his living room. C1 had a physician's order dated April 4, 2016 for Oxycodone 5 milligrams (mg) 1-2 tablets as needed every 4-6 hours, April 7, 2016 for Oxycodone 5mg 1 tablet as needed every 3 hours, April 7, 2016 for Oxycontin 15mg 1 tablet every 12 hours, and April 12, 2016 Oxycodone 5mg 1 tablet as needed every 3 hours. C2's file was reviewed. C2 received services from the licensee for transfer assistance when bathing according to a service agreement dated April 9, 2014. C2 did not receive medication management service from the provider. C2 kept her medications in the medicine cabinet in the bathroom. C2 had a physician's order dated April 15, 2016 for Hydrocodone/APAP 5/325mg, 1 tablet twice daily as needed. Interview with housing director (HD)-C on July 28, 2016 at 2:50 p.m. revealed family member (F)-D reported to HD-C on April 20 and April 22, 2016 that F-D suspected a staff member was taking medications from C1 and C2 because they were missing medications. HD-C sat in the apartment for C1 and C2 on April 22, 2016 while C1 and C2 were out of the apartment at supper and observed unlicensed professional (ULP)-E knock on the door, enter the apartment, pour medications from C1's medication bottle that was on the table in the living room, and leave the apartment. HD-C checked the pill bottle and said it was empty. HD-C said she checked the bottle when she entered the apartment and the bottle previously contained medications belonging to C1	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H23595	A. BUILDING: _____ B. WING _____	C 08/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME CARE SERVICES	201 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087

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02015	Continued From page 10 prior to ULP-E taking the medications. HD-C said she notified the police. HD-C said police came to the facility and ULP-E admitted she took pills from clients a few times. She said police searched ULP-E and discovered eight pills belonging to C1. HD-C admitted she did not notify the state agency to report the suspected financial exploitation on April 20, 2016 nor the confirmed financial exploitation on April 22, 2016. Interview with registered nurse (RN)-B on July 28, 2016 at 1:06 p.m. revealed she was made aware the week following April 14, 2016 by F-D that F-D suspected medications belonging to C1 and C2 were stolen. RN-B revealed she was also made aware ULP-E was suspected and admitted to taking medications from C1 and C2 on April 22, 2016. RN-B admitted she did not notify the state agency to report the suspected financial exploitation when made aware the week following April 14, 2016 nor the confirmed financial exploitation on April 22, 2016. An undated policy titled "Vulnerable Adult Reporting" reads on page one "a report of suspected or witnessed maltreatment is to be made to the common entry point." In addition the policy reads on page one "all employees caring for Home Care Services clients MUST REPORT any suspected or witnessed incidents that appears to be suspected abuse, neglect. or financial exploitation and the Director or RN will make a report to the CEP as soon as possible." The policy states on page four "The Vulnerable Adult Act requires that the program submit a report of each reportable incident to the MAARC within 24 hours of notification." TIME PERIOD FOR CORRECTION: Twenty-one	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02015	Continued From page 11 (21) days.	02015		