Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Eaglecrest Senior Housing LLC
2945 Lincoln Drive
Roseville, MN 55113
Ramsey County

Report#: HL27952005

Date: August 1, 2016

Date of Visit: April 11, 2016
Time of Visit: 9:00 a.m. – 1:30 p.m.

By: Darin Hatch, Special Investigator

Type of Facility: ☐ Nursing Home ☐ HHA ☒ Home Care Provider
☐ SLF ☐ ICF/IID
☐ Hospital ☐ Other: ______

☒ Facility Self Report ☐ Complaint

Allegation(s): **It is alleged** that a client was financially exploited when the alleged perpetrator took the client's pain medication for his/her own personal use.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☐ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☐ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)

☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☑ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

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

☐ Abuse ☐ Neglect ☑ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Based on a preponderance of evidence financial exploitation occurred when the alleged perpetrator (AP) took 39 Oxycodone tablets, an opioid pain medication, from the client for her/his own personal use.

The client received services from the provider for activities of daily living, housekeeping, laundry, meals, and medication administration. The client had a physician's order for Oxycodone 5/325 milligrams (mg) one tablet scheduled twice daily for pain. The medication was stored in the client's locked kitchen cabinet, in a locked box, and the 39 tablets were packaged in bubble packs. The client had two bubble pack cards, one for the morning dose and one for the evening dose.

Interview with facility staff revealed the AP was in the public bathroom on the second floor when a staff heard a rustling sound of a bubble pack. Later another staff went into the public bathroom on the second floor and discovered one Oxycodone 5/325 mg tablet on the floor. The staff notified the nurse. The nurse knew the client was the only client on the 2nd floor with a physician's order for Oxycodone. Staff went to the client's room and discovered both of the client's bubble packs of Oxycodone were missing from the client's locked medication storage box. Staff searched the bathroom on the 2nd floor and discovered both bubble packs for the client in the trash, wrapped in paper towels, and emptied of 39 tablets. Staff reported the AP was the only staff assigned to the client that shift. The nurse called the clinical administrator. The clinical administrator called police.

A police report revealed police were contacted to come to the facility for a theft of medication from a client. Police responded and interviewed staff and the AP. The AP admitted to police s/he took the 39 tablets of Oxycodone from the client, ingested five of them, and hid the remaining tablets in her/his vehicle. Police searched the AP's car, discovered the Oxycodone tablets belonging to the client, arrested the AP, and forwarded their investigation findings to the county attorney for formal charges.

The AP was offered an interview but declined the offer to interview in person or via the telephone.

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

State licensing orders were issued: ☒ Yes ☐ No If no, specify: ___________

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

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

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

State licensing orders were issued: ☒ Yes ☐ No If no, specify: ___________

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

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

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.

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.

The Investigation included the following:

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

☒ Medical Records

☒ Medication Administration Records

☒ Facility Incident Reports

☒ ADL (Activities of Daily Living) Flow Sheets

☒ Physician Orders

☒ Nurses Notes

☐ Activities Reports

☐ Therapy and/or Ancillary Services Records

☐ Skin Assessments

☒ Service Plan

☒ Care Guide

☐ Treatment Sheets

☐ Physician Progress Notes

☐ Laboratory and X-ray Reports

☐ Social Service Notes

☐ Meal Intake Records

☐ Weight Records

☒ Assessments

☒ Care Plan Records

☐ Other, specify: ________

Other pertinent medical records:

☐ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☐ Death Certificate

☒ Police Report ☐ Other, specify: ________

Additional facility records:

☐ Resident/Family Council Minutes

☒ Personnel Records/Background Check, etc.

☒ Staff Time Sheets, Schedules, etc.

☒ Facility In-service Records

☒ Facility Internal Investigation Reports

☒ Facility Policies and Procedures

☐ Call Light Audits

☐ Other, specify: ________

Number of additional resident(s) reviewed: 0

Were residents selected based on the allegation(s)? ○ Yes ○ No ◉ N/A Specify: No additional 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: Facility self-report

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: 1

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

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: Contact was made but the AP declined to interview.

Attempts to contact: Date/time: ______ Date/time: ______ Date/time: ______

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

Were contacts made with any of the following:
☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify __________

Observations were conducted related to:

☐ Wound Care	☒ Medication Pass	☐ Meals
☐ Personal Care	☒ Dignity/Privacy Issues	☐ Restorative Care
☐ Nursing Services	☒ Safety Issues	☒ Facility Tour
☐ Infection Control	☒ Cleanliness	☐ Injury
☐ Use of Equipment	☐ Transfers	☐ Incontinence
☐ Call Light	☐ Other: __________	

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

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

Were photographs taken: ○ Yes ◉ No Specify: __________

xc: Health Regulation Division - Home Care & Assisted Living Program
The Office of Ombudsman for Mental Health and Developmental Disabilities
The Office of Ombudsman for Long-Term Care
Roseville City Police Department
Ramsey County Attorney
Roseville 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
	H27952	A. BUILDING: ____ B. WING ____	C 04/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLECREST	2945 LINCOLN DRIVE ROSEVILLE, MN 55113

(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 LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order is 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 April 11, 2016, a complaint investigation was initiated to investigate complaint #HL27952005. At the time of the survey, there were 130 clients that were receiving services under the comprehensive license. The following correction order is issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.	
0 325	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights:	0 325		

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

Minnesota Department of Health

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0 325	Continued From page 1 (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; This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to ensure that one of one clients (C1) reviewed was free from maltreatment when they were financial exploitation by nursing assistant (NA)-F who stole C1's narcotic medications. The violation is issued as a level 2 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: According to the client's service agreement and care plan dated January 25, 2016, C1's received services from the comprehensive home care provider for activities of daily living, housekeeping, laundry, meals, and medication administration. C1 had a physician's order for Oxycodone 5/325 milligrams (mg), one tablet scheduled twice daily for pain. The medication was stored in C1's locked kitchen cabinet, in a locked box, and the 39 tablets were packaged in bubble packs. C1 had two bubble pack cards, one for the morning dose and one for the evening dose. The morning	0 325		

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0 325	Continued From page 2	0 325		

card contained 16 tablets and the evening card contained 23 tablets.

Interview with the clinical administrator (CA)-A on April 11, 2016 at 11:18 a.m. revealed she was called by the facility registered nurse (RN)-B at about 7:00 p.m. on March 2, 2016 re that unlicensed professional (ULP)-E found an Oxycodone tablet on the floor in the public bathroom on the 2nd floor. RN-B knew C1 was the only client on the 2nd floor with a physician's order for Oxycodone. ULP-D and ULP-D went to C1's room and discovered both of C1's bubble packs of Oxycodone were missing from C1's locked medication storage box. ULP-D and ULP-E searched the bathroom on the 2nd floor and discovered both bubble packs for C1 in the trash, wrapped in paper towels, and emptied of 39 tablets. ULP-D and ULP-E notified RN-B. RN-B called CA-A and CA-A called police and later the common entry point.

Interview with RN-B on April 19, 2016 at 8:39 a.m. revealed ULP-E found an Oxycodone tablet on the floor in the public bathroom on the 2nd floor and brought it to RN-B at around 6:00 p.m. on March 2, 2016. RN-B knew C1 was the only client on the 2nd floor with a physician's order for Oxycodone. ULP-D and ULP-E went to C1's room and discovered both of C1's bubble packs of Oxycodone were missing from C1's locked medication storage box. ULP-D and ULP-E searched the bathroom on the 2nd floor and discovered both bubble packs for C1 in the trash, wrapped in paper towels, and emptied of 39 tablets. ULP-D and ULP-E notified RN-B. RN-B called CA-A and CA-A called police. RN-B said NA-F was the only staff assigned to C1 that day.

Interview with ULP-D on April 19, 2016 at 9:47

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0 325	Continued From page 3 a.m. revealed ULP-D saw NA-F grab her purse and go into the bathroom on the second floor at around 3:00 p.m. Later in the shift ULP-E went into the bathroom on the 2nd floor and discovered one Oxycodone 5/325 mg on the floor at around 6:00 p.m. on March 2, 2016. ULP-E told RN-B and ULP-D. ULP-D recalled she heard a rustling sound like that of a bubble pack when NA-F was in the bathroom at around 3:00 p.m. RN-B knew C1 was the only client on the 2nd floor with a physician's order for Oxycodone. ULP-D and ULP-E went to C1's room and discovered both of C1's bubble packs of Oxycodone were missing from C1's locked medication storage box. ULP-D and ULP-E searched the bathroom on the 2nd floor and discovered both bubble packs for C1 in the trash, wrapped in paper towels, and emptied of 39 tablets. ULP-D said NA-F was the only staff assigned to C1 that day. ULP-D and ULP-E notified RN-B. Interview with ULP-E on April 20, 2016 at 2:56 p.m. revealed ULP-E saw NA-F grab her purse and go into the bathroom on the second floor at around 3:00 p.m. Later in the shift ULP-E went into the bathroom on the 2nd floor and discovered one Oxycodone 5/325 mg on the floor. ULP-E told RN-B and ULP-D. ULP-E said ULP-D said she heard a rustling sound like that of a bubble pack when NA-F was in the bathroom. RN-B knew C1 was the only client on the 2nd floor with a physician's order for Oxycodone. ULP-D and ULP-E went to C1's room and discovered both of C1's bubble packs of Oxycodone were missing from C1's locked medication storage box. ULP-D and ULP-E searched the bathroom on the 2nd floor and discovered both bubble packs for C1 in the trash, wrapped in paper towels, and emptied of 39 tablets. ULP-E said NA-F was the only staff assigned to C1 that day. ULP-D and ULP-E	0 325		

Minnesota Department of Health

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0 325	Continued From page 4 notified RN-B. A police report dated March 2, 2016 revealed police were contacted to come to the facility for a theft of medication from a client. Police responded interviewed CA-A, RN-B, ULP-D, ULP-E, and NA-F. NA-F admitted to police she took the 39 tablets of Oxycodone from C1, ingested five of them, and hid the remaining tablets in her vehicle. Police searched NA-F's car, discovered Oxycodone tablets belonging to C1, arrested NA-F, and forwarded their investigation findings to the county attorney for formal charges. Document review revealed a policy dated August 5, 2014 and titled "Vulnerable Adult Abuse Prevention Plan" which states on page 2 "any form of resident abuse, neglect, or exploitation will not be tolerated" and it is the objective "to protect each resident from maltreatment by care givers." TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 325		