MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: Lifesprk LLC		**Report Number:** HL30082003	**Date of Visit:** November 21, 2016
Facility Address: 4570 West 77th Street Ste 350		**Time of Visit:** 9:00 a.m. - 5:30 p.m.	**Date Concluded:** January 9, 2017
Facility City: Edina		**Investigator's Name and Title:** Darin Hatch, Special Investigator Kathy Smith, RN, Special Investigator	
State: Minnesota	**ZIP:** 55435	**County:** Hennepin	

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was financially exploited when s/he had approximately 50-56 pills missing.

☒ 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 occurred when an unknown staff member took 50-56 tablets of hydrocodone/APAP-5/325 milligrams (mg) from the client.

The client received home care services with medication management according to a service agreement and care plan. The client had a physician's order for hydrocodone/APAP-5/325 milligrams (mg) two tablets twice a day, morning and evening. The pharmacy provided the medication as two cards, one labeled morning and another labeled evening. Each contained 60 tablets.

Observations and interviews with staff conducted during the on-site investigation revealed clients that receive medication management had their medications stored in a locked cabinet in their rooms. In that locked cabinet were two locked tool boxes. One tool box contained a one-month supply of client medications, both scheduled and as-needed, in blister packages. Unlicensed staff have access to the locked cabinet and this first toolbox. Unlicensed staff document medication administration by signing both the medication administration record (MAR) and the blister pack when they administer a medication. The second tool box contains surplus medications and is only accessible by licensed staff. Staff indicated that for both boxes, licensed staff only periodically account for the medications.

Interviews with staff revealed a nurse discovered the client's evening card of hydrocodone/APAP was missing when the nurse went to destroy the medication after the client's discharge from the facility. Staff said they suspected 50 to 56 tablets of hydrocodone/APAP-5/325 (mg) belonging to the client were taken by a staff member. The facility was unable to determine an alleged perpetrator, and was unable to determine exactly how many tablets were missing or when the tablets went missing. However, the facility

determined that staff members were not following facility policy and procedures regarding medication management.

Observations and document review confirmed that the facility was unable to account for one medication card, which should have contained over 50 tablets of hydrocodone/APAP. However, because the medication supply was not being regularly counted, and because the narcotics count sheets which were present contained other errors in the quantity of tablets, it was not possible to determine when the card went missing.

Law enforcement also conducted an investigation, but were unable to determine who might have taken the medications. The police closed the investigation.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 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 facility is responsible for the financial exploitation. The facility failed to implement their medication management policies and procedures when they failed to ensure security and accountability for the overall management, control, and disposition of the controlled substances they managed.

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:

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Care Plan Records
- [x] Facility Incident Reports

☒ 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: 3

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

Specify: _____

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: Moved to another facility, not cognitively intact

Did you interview additional residents? ○ Yes ◉ No

Total number of resident interviews: 0

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 3

Physician Interviewed: ◯ Yes ◉ No

Nurse Practitioner Interviewed: ◯ Yes ◉ No

Physician Assistant Interviewed: ◯ Yes ◉ No

Interview with Alleged Perpetrator(s): ◯ Yes ◉ No ◯ N/A Specify: No AP identified

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:

☒ Medication Pass

☒ Cleanliness

☒ Dignity/Privacy Issues

☒ Safety Issues

☒ 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: Medication packaging

cc:

Health Regulation Division - Home Care & Assisted Living Program

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Edina Police Department

Hennepin County Attorney

Edina 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
	H30082	A. BUILDING: _____ B. WING _____	C 12/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFESPRK LLC	4570 WEST 77TH STREET STE 350 EDINA, MN 55435

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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 November 21, 2016, a complaint investigation was initiated to investigate complaint #HL30082003. At the time of the survey, there were 119 clients that were receiving services under the comprehensive license but only 20 clients received medication management services from the licensee. 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. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 1441.474 subd. 11 (b) (1) (2)	
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:	0 325		

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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 reviewed (C1) was free from financial exploitation when an unknown staff person took medications from C1. The violation occurred 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: C1's record was reviewed. C1 received comprehensive home care services with medication management according to a service agreement and care plan dated May 06, 2015. C1 had a physician's order dated May 13, 2016 for hydrocodone/APAP-5/325 milligrams (mg) two tablets twice a day, morning and evening. The pharmacy sent two cards, one labeled morning that contained 60 tablets, and the other labeled evening that contained 60 tablets. Observations and interviews with staff conducted during the onsite investigation revealed clients that receive medication management have their medication stored in a locked cabinet in their rooms. In that locked cabinet are two tool boxes that are also locked. One tool box contains a one	0 325		

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0 325	Continued From page 2 month supply of scheduled client medications and as needed client medications that come in blister packages. Unlicensed professional (ULP) staff have access to the locked cabinet and this ULP toolbox containing medication for clients. ULP staff administer medication by checking the medication administration record (MAR) and signing it, and the blister package, when they administer a medication. The second tool box contains surplus medications, a MAR, and is only accessible by licensed staff. Staff indicated during interviews that licensed staff only periodically account for the medications in both boxes. Document review during the onsite investigation revealed an untitled document dated September 12, 2016 that indicated licensed practical nurse (LPN)-B discovered the evening card of hydrocodone/APAP for C1 was missing when she went to destroy the medication because C1 had been discharged from the facility on September 12, 2016. The document indicated the facility suspected 50 to 56 tablets belonging to C1 were missing and taken by a staff member. The document indicated the facility conducted an investigation, was unable to determine an alleged perpetrator, and was unable to determine how many tablets were actually missing or when the tablets went missing. The facility notified the Minnesota Adult Abuse Reporting Center and police. Document review revealed a police report dated September 12, 2016 which indicated police conducted an investigation but were unable to determine who the alleged perpetrator was and closed the investigation. During an interview on November 21, 2016 at	0 325		

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0 325	Continued From page 3 4:10 p.m. LPN-B said she was reviewing medications for destruction for C1 after C1 was discharged from the facility on September 12, 2016 and noticed the evening medication card of hydrocodone/APAP-5/325 mg for C1 was missing. LPN-B said she reviewed the medication administration record and narcotic record log for C1 and said she suspected 50 to 56 tablets were taken by a staff member. During interview on November 21, 2016 at 3:33 p.m. registered nurse (RN)-A said she was notified of missing medications for C1 by LPN-B on September 12, 2016. RN-A conducted an investigation, suspected staff were responsible, and called police. RN-A said the investigation did not reveal any suspects but did reveal staff members were not following facility policy and procedures regarding medication management. An undated policy titled "List of Applicable Rules & Regulations" indicates on page one the facility adopts the Home Care Bill of Rights and clients have a right to be free from all forms of maltreatment. 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 document review and interview the licensee failed to ensure that one of one incidents	0 805		

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0 805	Continued From page 4 of suspected financial exploitation reviewed was reported to the Minnesota Adult Abuse Reporting Center (MAARC) as required. The violation occurred 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: C1's record was reviewed. C1 received comprehensive home care services with medication management according to a service agreement and care plan dated May 06, 2015. C1 had a physician's order dated May 13, 2016 for hydrocodone/APAP-5/325 milligrams (mg) two tablets twice a day, morning and evening. The pharmacy sent two cards, one labeled morning that contained 60 tablets, and the other labeled evening that contained 60 tablets. Document review during the onsite investigation revealed an untitled document dated September 12, 2016 that indicated licensed practical nurse (LPN)-B discovered the evening card of hydrocodone/APAP for C1 was missing when she went to destroy the medication because C1 had been discharged from the facility on September 12, 2016. The document indicated the facility suspected 50 to 56 tablets belonging to C1 were missing and taken by a staff member. The document indicated the facility conducted an investigation, was unable to determine an alleged perpetrator, and was unable to determine how many tablets were actually missing or when the tablets went missing. The facility did not notify the Minnesota Adult Abuse Reporting Center until	0 805		

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0 805	Continued From page 5 September 16, 2016. During an interview on November 21, 2016 at 4:10 p.m. LPN-B said she was reviewing medications for destruction for C1 after C1 was discharged from the facility on September 12, 2016 and noticed the evening medication card of hydrocodone/APAP-5/325 mg for C1 was missing. LPN-B said she reviewed the medication administration record and the narcotic log for C1 and said she suspected 50 to 56 tablets were taken by a staff member. LPN-B admitted she did not know the protocol for vulnerable adult reporting and did not report the suspected financial exploitation to the MAARC. During interview on November 21, 2016 at 3:33 p.m. registered nurse (RN)-A said she was notified on September 12, 2016 by LPN-B that medications belonging to C1 were missing. RN-A said she conducted an investigation and notified police because she suspected an unknown staff member had taken the medications belonging to C. RN-A admitted she did not notify the MAARC until September 16, 2016. An undated policy titled "Vulnerable Adult & Reporting Requirements" indicates on page one "a report of suspected maltreatment is required to the MAARC by the supervisor immediately within twenty-four hours from the maltreatment report." TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 805		
0 900 SS=F	144A.4792, Subd. 1 Medication Management; Comprehensive	0 900		

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0 900	Continued From page 6 Subdivision 1. Medication management services; comprehensive home care license. (a) This subdivision applies only to home care providers with a comprehensive home care license that provide medication management services to clients. Medication management services may not be provided by a home care provider who has a basic home care license. (b) A comprehensive home care provider who provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and client and client representative, if any; disposing of unused medications; and educating clients and client representatives about	0 900		

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0 900	Continued From page 7 medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 22. This MN Requirement is not met as evidenced by: Based on document review and interview the licensee failed to implement their medication management policies and procedures for two of four clients (C1) and (C2) reviewed when the licensee failed to ensure security and accountability for the overall management, control, and disposition of the controlled substances they managed. 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: C1's record was reviewed. C1 received comprehensive home care services with medication management according to a service agreement and care plan dated May 06, 2015. C1 had a physician's order dated May 13, 2016 for hydrocodone/APAP-5/325 milligrams (mg) two tablets twice a day, morning and evening. The pharmacy sent two cards, one labeled morning	0 900		

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0 900	Continued From page 8 that contained 60 tablets, and the other labeled evening that contained 60 tablets. C2's record was reviewed. C2 received comprehensive home care services with medication management according to a service agreement and care plan dated August 13, 2015. C2 had a physician's order dated October 20, 2016 for hydrocodone/APAP-5/325 mgs., one tablet three times a day, morning, afternoon, and evening. The pharmacy sent three cards, each one contained 30 tablets, and were labeled morning, afternoon, and evening. Observations and interviews with staff conducted during the onsite investigation revealed clients that receive medication management have their medication stored in a locked cabinet in their rooms. In that locked cabinet are two tool boxes that are also locked. One tool box contains a one month supply of scheduled client medications and as needed client medications that come in blister packages. Unlicensed professional (ULP) staff have access to the locked cabinet and this ULP toolbox containing medication for clients. ULP staff administer medication by checking the medication administration record (MAR) and signing it and the blister package when they administer a medication. The second tool box contains surplus medications, a MAR, and is only accessible by licensed staff. Staff indicated during interviews that licensed staff only periodically account for the medications in both boxes. Document review during the onsite investigation revealed an untitled document dated September 12, 2016 that indicated licensed practical nurse (LPN)-B discovered the evening card of hydrocodone/APAP for C1 was missing when she	0 900		

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0 900	Continued From page 9 went to destroy the medication because C1 had been discharged from the facility on September 12, 2016. The document indicated the facility suspected 50 to 56 tablets belonging to C1 were missing. The document indicated the facility conducted an investigation but was unable to determine an alleged perpetrator and was unable to determine how many actual tablets were missing or when the tablets went missing. Observations made during the onsite investigation on November 21, 2016 at 3:20 p.m. of both of C2 ' s medication boxes revealed the narcotic count sheets present in the boxes were not accurate. The narcotic count sheets signed by LPN-B indicated a total of 101 tablets of hydrocodone/APAP 5/325 mg should be present in both boxes but only a total of 47 tablets of hydrocodone/APAP 5/325 mg were present in both boxes. RN-A and LPN-B were unsure if C2 was missing 54 tablets of hydrocodone/APAP 5/325 mg or if an error had occurred in the counting or documentation of the medication for C2. Interviews with registered nurse (RN)-A and LPN-B on November 21, 2016 at 3:20 p.m. revealed both nurses admitted the counts for C1 and C2 were not accurate. The nurses did not know exactly how many tablets of hydrocodone/APAP 5/325 mg were missing for C1. The nurses also said they did not know why there was a discrepancy of 54 tablets of hydrocodone/APAP 5/325 mg for C2. LPN-B said during re-interview at 4:10 p.m. on November 21, 2016 she was not able to determine the exact number of tablets that were missing for C1 because she had not correctly documented the narcotic counts in the client's narcotic records. LPN-B said she did not count	0 900		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 900	Continued From page 10 and document the records correctly for C1 when she added medication recently to the ULP box from the licensed staff box and admitted knowing the count was incorrect. LPN-B said licensed and unlicensed staff have not been conducting counts lately as required, licensed and unlicensed staff have been making mistakes in counting narcotic medications, licensed and unlicensed staff need more licensed staff supervision facility wide, and the problems are widespread throughout the facility. An undated policy titled "Medication Management Services" indicates on page one an assessment will occur of the client's medication management needs "consistent with current practice standards and guidelines. The assessment will identify interventions needed in management of medications to prevent diversion of medications." The policy further indicates on page two the LPN will review each client's medication record when setting up medications and at other appropriate times based on the client's needs to verify that staff are administering the medications as prescribed and documenting the administration properly and there are no signs of medication diversion." An undated policy titled "Controlled Substances-Community" indicates on page one the purpose of the policy is: "to ensure that narcotic administration and management is within accepted professional standards and practice" and "to maintain accurate records of narcotic inventory, wastage and administration thus preventing or reducing the potential for substance abuse on home care cases where Lifesprk staff are administering the narcotics/controlled substances."	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H30082	A. BUILDING: _____ B. WING _____	C 12/02/2016

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0 900	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
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.	02015		

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02015	Continued From page 12 (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (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 document review and interview the licensee failed to ensure that one of one incidents of suspected financial exploitation reviewed was reported to the Minnesota Adult Abuse Reporting Center (MAARC) as required. The violation occurred 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	02015		

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02015	Continued From page 13 occasionally. The findings include: C1's record was reviewed. C1 received comprehensive home care services with medication management according to a service agreement and care plan dated May 06, 2015. C1 had a physician's order dated May 13, 2016 for hydrocodone/APAP-5/325 milligrams (mg) two tablets twice a day, morning and evening. The pharmacy sent two cards, one labeled morning that contained 60 tablets, and the other labeled evening that contained 60 tablets. Document review during the onsite investigation revealed an untitled document dated September 12, 2016 that indicated licensed practical nurse (LPN)-B discovered the evening card of hydrocodone/APAP for C1 was missing when she went to destroy the medication because C1 had been discharged from the facility on September 12, 2016. The document indicated the facility suspected 50 to 56 tablets belonging to C1 were missing and taken by a staff member. The document indicated the facility conducted an investigation, was unable to determine an alleged perpetrator, and was unable to determine how many tablets were actually missing or when the tablets went missing. The facility did not notify the Minnesota Adult Abuse Reporting Center until September 16, 2016. During an interview on November 21, 2016 at 4:10 p.m. LPN-B said she was reviewing medications for destruction for C1 after C1 was discharged from the facility on September 12, 2016 and noticed the evening medication card of hydrocodone/APAP-5/325 mg for C1 was missing. LPN-B said she reviewed the medication administration record and the narcotic log for C1 and said she suspected 50 to 56	02015		

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02015	Continued From page 14 tablets were taken by a staff member. LPN-B admitted she did not know the protocol for vulnerable adult reporting and did not report the suspected financial exploitation to the MAARC. During interview on November 21, 2016 at 3:33 p.m. registered nurse (RN)-A said she was notified on September 12, 2016 by LPN-B that medications belonging to C1 were missing. RN-A said she conducted an investigation and notified police because she suspected an unknown staff member had taken the medications belonging to C. RN-A admitted she did not notify the MAARC until September 16, 2016. An undated policy titled "Vulnerable Adult & Reporting Requirements" indicates on page one "a report of suspected maltreatment is required to the MAARC by the supervisor immediately within twenty-four hours from the maltreatment report." TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02015		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 15, 2017

Mr. Joel Theisen, RN, Administrator
Lifesprk LLC
4570 West 77th Street Ste 350
Edina, MN 55435

RE: Complaint Number HL30082003

Dear Mr. Theisen:

On June 2, 2017 an investigator of the Minnesota Department of Health, Office of Health Facility Complaints completed a re-inspection of your facility, to determine correction of orders found on the complaint investigation completed on December 2, 2016 with orders received by you on January 9, 2017. At this time these correction orders were found corrected and are listed on the attached State Form: Revisit Report.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Please feel free to call me with any questions.

Sincerely,

Matthew Heffron

Matthew Heffron, JD, NREMT
Health Regulations Division
Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 281-9796

MH/ja
Enclosure

cc: Home Health Care Assisted Living File
Hennepin County Adult Protection
Office of Ombudsman
MN Department of Human Services