



Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:

Augustana HCC of Apple Valley
14650 Garrett Avenue
Apple Valley, MN 55124
Dakota County

Report#: H5264054

Date: November 20, 2015

Date of Visit: September 21, 2015
Time of Visit: 8:30 a.m.-6:00 p.m.

By: Jacob Maberera, RN, 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 resident was financially exploited when a staff, alleged perpetrator (AP) made multiple unauthorized charges to resident's credit card.

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 the resident's credit card, used it to make purchases for his/her own personal use and without the resident's permission or knowledge.

The resident was admitted to the facility for short term rehabilitation after a hospitalization. Review of the resident's record indicated that the resident was moderately impaired in her/his cognition but was able to make his/her daily decisions and needs known.

Document review and interviews revealed that a police officer reported to the facility staff that the resident had unauthorized charges that were made on her/his credit card while the resident was at the facility. Through their investigation the police were able to determine that the unauthorized charges were made over a three day period between the hours of 7:00 a.m. and 9:00 a.m. in Walmart, Cub foods and a Shell gas station, all stores located in the Apple Valley area. The video surveillance footage provided by Walmart store showed an individual wearing scrubs using the resident's credit card to make purchases on one of the three different occasions that the resident's credit card was used in Walmart. The police showed the facility staff the video and facility staff positively identified the individual in the video as the AP.

The resident was interviewed and stated that s/he did not give anyone permission to use his/her credit card to make purchases while residing at the facility.

The AP admitted to the police that she took the resident's credit card and used it to make purchases for her own use without the resident's permission or knowledge at Walmart, Cub foods and Shell gas station. Charges were filed against the AP.

The AP failed to respond to a subpoena issued for an in person interview with the OHFC investigator.

The AP was terminated from employment at the facility.

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 had trained the AP regarding maltreatment of vulnerable adults. Training records bearing AP's signature indicated that the AP had received training regarding maltreatment of vulnerable adults that included financial exploitation and signed that s/he understood the material that was taught. The AP admitted to the police that s/he knew that it was wrong to take the resident's credit card and use it to make purchases for his/her own use.

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:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) – Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: Yes No If no, specify: _____
(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) 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:

- | | |
|---|--|
| <input checked="" type="checkbox"/> Medical Records | <input checked="" type="checkbox"/> Care Guide |
| <input type="checkbox"/> Medication Administration Records | <input type="checkbox"/> Treatment Sheets |
| <input checked="" type="checkbox"/> Facility Incident Reports | <input checked="" type="checkbox"/> Physician Progress Notes |
| <input type="checkbox"/> ADL (Activities of Daily Living) Flow Sheets | <input type="checkbox"/> Laboratory and X-ray Reports |
| <input checked="" type="checkbox"/> Physician Orders | <input checked="" type="checkbox"/> Social Service Notes |

- Nurses Notes
- Meal Intake Records
- Activities Reports
- Weight Records
- Therapy and/or Ancillary Services Records
- Assessments
- Skin Assessments
- Care Plan Records
- Service Plan
- 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: Facility's grievances and concerns

Number of additional resident(s) reviewed: 2

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: Discharged

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): Yes No N/A Specify: Facility 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: 15

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

Tennessee Warning given as required: Yes No

Total number of staff interviews: 6

Physician interviewed: Yes No

Nurse Practitioner interviewed: Yes No

Physician Assistant interviewed: Yes No

Interview with Alleged Perpetrator(s): Yes No N/A Specify: _____

Attempts to contact: Date/time: 9/22/15 at 4:06 p.m. Date/time: 9/29/15 at 8:55 a.m. Date/time: 10/19/15 at 11:18 a.m.

If unable to contact was subpoena issued: Yes , date subpoena was issued 9/25/2015 for in person interview scheduled for 10/15/2015 at 2:00 p.m. AP called on 10/12/15 at 9 a.m. and rescheduled in person interview to 10/19/15 at 11:00 a.m. but did not appear. No

Were contacts made with any of the following:

- Emergency personnel
- Police Officers
- Medical Examiner
- Other: Specify County Attorney

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: _____

Was equipment being operated in safe manner: Yes No N/A Specify: _____

Were photographs taken: Yes No Specify: _____

xc: Health Regulation Division - Licensing & Certification
 Minnesota Board of Examiners for Nursing Home Administrators
 Apple Valley City Police Department
 Dakota County Attorney
 Apple Valley City Attorney

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/01/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/12/2015
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
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F 000	INITIAL COMMENTS	F 000			
F 497 SS=E	<p>An abbreviated standard survey was conducted to investigate case #H5264054. As a result, the following deficiency is issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.</p> <p>483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE</p> <p>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the competency of nursing assistants, for 3 of 4 nursing assistant reviewed, who did not have an annual performance reviews or performance improvement plan that addressed the quality of care provided to residents. This had the potential to affect all 164 residents residing at the facility.</p>	F 497			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 497	<p>Continued From page 1</p> <p>Findings include:</p> <p>The personnel file of Nursing Assistant (NA)-C indicated that NA-C was hired on 3/28/1995 and had worked at the facility for over twenty years as a nursing assistant. The record lacked a documentation of performance review for the year 2015. NA-C's performance had not been appraised or reviewed with NA-C after her anniversary hire date of 3/28/2015. NA-C's last performance review was appraised on 8/11/2014.</p> <p>The personnel file of NA-D indicated that NA-D was hired on 4/23/2012 had worked at the facility for over three years as a nursing assistant. The record lacked a documentation of performance review for the year 2015. NA-D's performance had not been appraised or reviewed with NA-D after her anniversary hire date of 4/23/2015. NA-C's last performance review was appraised on 6/2/2014.</p> <p>The personnel file of NA-E indicated that NA-E was hired on 6/6/2011 had worked at the facility for over four years as a nursing assistant. The record lacked a documentation of performance review for the year 2015. NA-D's performance had not been appraised or reviewed with NA-D after her anniversary hire date of 6/6/2015. NA-C's last performance review was appraised on 8/8/2014.</p> <p>When interviewed on 9/21/15 at 3:00 p.m., facility's human resource director (HRD) verified that she was responsible for tracking performance evaluations to ensure that they are completed timely. HRD further stated that she compiles a monthly list of employees whose anniversary date falls in that month and hands it</p>	F 497		

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F 497	<p>Continued From page 2</p> <p>to the employee's supervisor for completion of performance reviews. She verified that performance reviews for nursing assistants were not up to date including performance reviews for NA-C, NA-D and NA-E.</p> <p>The facility's director of nursing (DON) was interviewed on 9/21/15 at 5:35 p.m., stated that the expectation is for nursing assistant performance reviews to be done timely. The DON was aware of the requirement for annual performance reviews of nursing assistants and stated that performance reviews are done based on employee's date of hire or the last time appraisal was done.</p> <p>The facility's policy titled "Performance Evaluation policy" revised 1/08 Directed that employee's performance evaluations shall be conducted yearly on the anniversary of the employee's hire date or some annual date as designated by Supervisor. The policy further directed that at the beginning of each month, human resources will notify department heads of employees who require a review that month and the department heads shall ensure that all evaluation forms are completed by the appropriate supervisory personnel, review all completed evaluations and ensure that completed evaluations are returned to human resources by the last day of the month.</p>	F 497		

Minnesota Department of Health

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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5264054. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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2 000	Continued From page 1 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
2 760	MN Rule 4658.0505 F. Responsibilities; DNS; Assigning, supervising, The written job description for the director of nursing services must include responsibility for: F. assigning, supervising, and evaluating the performance of all nursing personnel; This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the competency of nurse aides, for 3 of 4 nursing assistant reviewed, who did not have an annual performance reviews or performance improvement plan that addressed the quality of care provided to residents. This had the potential to affect all 164 residents residing at the facility. Findings include: The personnel file of Nursing Assistant (NA)-C indicated that NA-C was hired on 3/28/1995 and had worked at the facility for over twenty years as a nursing assistant. The record lacked a documentation of performance review for the	2 760		

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2 760	<p>Continued From page 2</p> <p>year 2015. NA-C's performance had not been appraised or reviewed with NA-C after her anniversary hire date of 3/28/2015. NA-C's last performance review was appraised with NA-C on 8/11/2014.</p> <p>The personnel file of NA-D indicated that NA-D was hired on 4/23/2012 had worked at the facility for over three years as a nursing assistant. The record lacked a documentation of performance review for the year 2015. NA-D's performance had not been appraised or reviewed with NA-D after her anniversary hire date of 4/23/2015. NA-D's last performance review was appraised with NA-D on 6/2/2014.</p> <p>The personnel file of NA-E indicated that NA-E was hired on 6/6/2011 had worked at the facility for over four years as a nursing assistant. The record lacked a documentation of performance review for the year 2015. NA-D's performance had not been appraised or reviewed with NA-D after her anniversary hire date of 6/6/2015. NA-E's last performance review was appraised with NA-E on 8/8/2014.</p> <p>When interviewed on 9/21/15 at 3:00 p.m., facility's human resource director (HRD) verified that she was responsible for tracking performance evaluations to ensure that they are completed timely. HRD further stated that she compiles a monthly list of employees whose anniversary date falls in that month and hands it to the employee's supervisor for completion of performance reviews. She verified that performance reviews for nursing assistants were not up to date including performance reviews for NA-C, NA-D and NA-E.</p> <p>The facility's director of nursing (DON) was</p>	2 760		
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2 760	<p>Continued From page 3</p> <p>interviewed on 9/21/15 at 5:35 p.m., stated that the expectation is for nursing assistant performance reviews to be done timely. The DON was aware of the requirement for annual performance reviews of nursing assistants and stated that performance reviews are done based on employee's date of hire or the last time appraisal was done.</p> <p>The facility's policy titled "Performance Evaluation policy" revised 1/08 Directed that employee's performance evaluations shall be conducted yearly on the anniversary of the employee's hire date or some annual date as designated by Supervisor. The policy further directed that at the beginning of each month, human resources will notify department heads of employees who require a review that month and the department heads shall ensure that all evaluation forms are completed by the appropriate supervisory personnel, review all completed evaluations and ensure that completed evaluations are returned to human resources by the last day of the month.</p> <p>SUGGESTED METHOD OF CORRECTION:</p> <p>Administrator or designee to develop and implement a system that ensures that performance appraisals are conducted with each nursing assistant annually.</p> <p>Time Period for Correction: Twenty one (21) days.</p>	2 760		
21850	<p>MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac. Bill of Rights</p> <p>Subd. 14. Freedom from maltreatment.</p>	21850		

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21850	<p>Continued From page 4</p> <p>Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from maltreatment of financial exploitation for 1 of 1 resident (R1) whose credit card was taken by a nursing assistant and used to make purchases for his/her own personal use.</p> <p>Findings include:</p> <p>A facility's vulnerable adult investigative report dated 7/6/15 revealed that an Apple Valley police officer reported to facility staff that R1 had fraudulent charges to her credit card that were made while R1 was residing at the facility. The facility and the Apple Valley police department initiated an investigation and nursing assistant (NA)-C was identified in a video surveillance footage from a local Walmart, showing NA-C making purchases using R1's credit card on 5/15/15, 5/17/15 and 5/18/15 between the hours of 7:00 a.m. and 9:00 a.m. The investigation file revealed NA-C was terminated from employment</p>	21850		
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21850	<p>Continued From page 5 at the facility on 7/10/15.</p> <p>R1's medical record was reviewed and revealed that R1's Brief Interview for Mental Status (BIMS), a cognitive assessment done on 5/11/15. BIMS revealed a score of 11, indicating that R1 was moderately impaired cognitively.</p> <p>During interview on 9/21/15 at 9:00 a.m., the facility's assistant director of nursing (ADON) stated that on 7/1/15 facility staff were notified by Apple Valley police officer that R1 had unauthorized charges that were made on R1's credit card during the length of R1's stay at the facility. ADON stated that an Apple Valley police officer showed pictures of a video surveillance footage from a local Walmart store to facility staff on 7/2/15 in an attempt to identify the individual using R1's credit card at the local Walmart store and they were able to identify the individual in the surveillance video footage pictures as NA-C. ADON further stated that an Apple Valley police officer contacted the facility at a later date and informed them that NA-C admitted to taking R1's credit card without R1's permission and used it to make purchases for NA-C's own personal use to the police. ADON stated that NA-C was terminated from her employment at the facility.</p> <p>When interviewed on 11/12/15 at 8:33 a.m., the facility's former director of nursing (DON) stated that she was contacted by an Apple Valley police officer who informed her that NA-C admitted to taking R1's credit card without R1's consent and used it to make purchases for NA-C's own personal use. The DON further stated that she spoke with NA-C and NA-C admitted to taking R1's credit card without R1's consent and used it to make purchases for NA-C's own personal use and the DON terminated NA-C's employment at</p>	21850		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00979	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/12/2015
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NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124
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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
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21850	<p>Continued From page 6</p> <p>the facility on 7/10/15.</p> <p>The facility's policy titled "Maltreatment of Vulnerable Adults" revised 10/15. The policy defines a vulnerable adult as "any and all the residents or inpatient of a licensed facility" and defined financial exploitation as willfully using, withholding, disposing of funds or property of the vulnerable adult and acquiring possession or control of funds or property of the vulnerable adult property through deception or fraud. The policy further directed that residents of Augustana care facilities have the right to be free from financial exploitation.</p> <p>SUGGESTED METHOD OF CORRECTION:</p> <p>The administrator, director of nursing (DON) could review and revise policies and procedures related to financial exploitation. Facility staff could be educated on the importance of following facility's vulnerable adult act policies. The quality assessment and assurance committee could implement monitoring to ensure compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	21850		
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POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245264	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 2/2/2016	Y3
NAME OF FACILITY AUGUSTANA HCC OF APPLE VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0497 Reg. # 483.75(e)(8) LSC _____	Correction Completed 12/11/2015	ID Prefix Reg. # LSC _____	Correction Completed	ID Prefix Reg. # LSC _____	Correction Completed
ID Prefix Reg. # LSC _____	Correction Completed	ID Prefix Reg. # LSC _____	Correction Completed	ID Prefix Reg. # LSC _____	Correction Completed
ID Prefix Reg. # LSC _____	Correction Completed	ID Prefix Reg. # LSC _____	Correction Completed	ID Prefix Reg. # LSC _____	Correction Completed
ID Prefix Reg. # LSC _____	Correction Completed	ID Prefix Reg. # LSC _____	Correction Completed	ID Prefix Reg. # LSC _____	Correction Completed
ID Prefix Reg. # LSC _____	Correction Completed	ID Prefix Reg. # LSC _____	Correction Completed	ID Prefix Reg. # LSC _____	Correction Completed

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/12/2015		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 00979	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 2/2/2016
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NAME OF FACILITY AUGUSTANA HCC OF APPLE VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20760	Correction	ID Prefix 21850	Correction	ID Prefix _____	Correction
Reg. # MN Rule 4658.0505 F.	Completed	Reg. # MN St. Statute 144.651 Subd. 14	Completed	Reg. # _____	Completed
LSC _____	02/02/2016	LSC _____	02/02/2016	LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 11/12/2015	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
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