DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Westwood of Duluth

Facility Address:
925 Kenwood Avenue

Facility City:
Duluth

State: Minnesota | **ZIP:** 55811 | **County:** Saint Louis

Report Number:
HL20935006

Date of Visit:
October 3 and 4, 2017

Time of Visit:
10:00 a.m. to 3:15 p.m.
10:15 a.m. to 2:15 p.m.

Date Concluded:
December 27, 2017

Investigator's Name and Title:
Rhylee Gilb, RN, Special Investigator

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was financially exploited when a facility staff member/alleged perpetrator used the client's medication for his/her own use.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

☒ 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 Client #1's medication cream and Client #2's pain medication were stolen by the alleged perpetrator (AP)

Client #1 received services from a provider licensed as a comprehensive home care provider. Client #1's service plan included assistance with medication administration. Client #1's cognitive exam score indicated a severe cognitive impairment. Client #1 was admitted with an order of Silvadene cream (a medicated cream) to be applied to both of his/her legs twice a day, with dressing changes to burn injuries. The Silvadene cream was not covered by insurance and the total cost to Client #1 was $101.78.

On a Wednesday, pharmacy records indicated a new jar of Silvadene cream was delivered for Client #1. Staff stated the Silvadene cream was kept on client #1's windowsill and the new jar was placed there next to a nearly empty jar.

Nine days later, on a Thursday, the alleged perpetrator (AP) received a burn to his/her wrist during supper. Multiple staff observed the AP leave his/her assigned unit and enter Client #1's room. The AP took the Silvadene cream and dressing supplies, sat a dining room table, and treated his/her burn. The AP did not

report his/her work injury.

Four days later, the licensed practical nurse (LPN) reported the new jar of Silvadene cream missing when s/he was completing Client #1's dressing change. The LPN stated s/he had seen the new jar previously, so s/he was going to open it as the old jar was almost empty. A search was conducted by staff for the new jar of Silvadene, but was not found. The home care provider ordered another jar of Silvadene at the home care provider's expense to replace the stolen medication. The management nurse re-educated the AP that using client medications for personal use was not tolerated.

Approximately two months later, the AP was suspected by the home care provider in another incident of missing medication involving a second client.

Client #2 received services from a provider licensed as a comprehensive home care provider. Client #2's service plan included assistance with medication administration. Client #2's cognitive exam score indicated a severe cognitive impairment. Client #2 had an order for scheduled Tramadol (a controlled pain medication) 50 milligrams, one tablet in the morning and two tablets at bedtime.

The home care provider nurses stored Tramadol in the medication room, in a locked narcotic box. The Tramadol count was logged in the narcotic log book. The nurses set up scheduled medication in pill boxes and then placed the filled pill box in a locked cabinet in each client's rooms for the resident assistants to administer. The home care provider had a universal keys for the client cabinets, therefore each of the resident assistant keys could open any room cabinet in each of the four units.

On a Monday evening at 5:10 p.m., the nurse set-up Client #2's pill box and logged the Tramadol amount of used. The filled pill box was placed in the locked cabinet in Client #2's room. The resident assistant assigned to Client #2 went to administer medication after supper and found the Tramadol missing from the Wednesday and Thursday slot, a total of six tablets. The resident assistant immediately reported this to the nurse. Multiple staff reported seeing the AP in Client #2's room earlier in the day. The AP was not assigned to Client #2's unit; the AP was assigned to a unit located on the first floor whereas Client #2's room was located on the second floor. The home care provider management staff began to monitor the AP more closely. The nurse replaced the missing Tramadol at 6:44 p.m., so Client #2 did not go without his/her medication.

Two weeks later, the nurse filled Client #2's pill box again on a Sunday. On Monday at 3:40 p.m., the management nurse completed a count of Client #2's Tramadol as the AP was scheduled to work the evening shift on the first floor. The management nurse instructed staff to call immediately if the AP was seen in Client #2's room. A resident assistant saw the AP leave Client #2's room and immediately alerted the nurses. The nurses checked Client #2's pill box and again the Tramadol was missing from the Wednesday and Thursday slot, a total of six tablets. At 4:50 p.m., the nurse replaced the missing Tramadol. The home care provider completed a drug diversion investigation and terminated the AP's employment.

Both Client #1 and Client #2 were unable to be interviewed due to cognitive status. Both families of Client #1 and Client #2 were interviewed and were unaware of the incidents.

During an interview, the AP denied the allegation. The AP stated s/he did use the Silvadene cream to treat a burn, but did not steal the jar. Also, the AP stated s/he did not take Client #2's Tramadol and stated s/he was in his/her room to visit.

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 AP received vulnerable adult training and was also re-educated after taking Client #1's medication for personal use, but chose to take medications from both clients. In both incidents, the AP was assigned to a different unit, but had left his/her assigned area and was seen by other staff in the units when both medications were stolen.

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 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 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

(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:

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] Treatment Sheets
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] ADL (Activities of Daily Living) Flow Sheets
- [x] Service Plan

Other pertinent medical records:

Additional facility records:

☒ Staff Time Sheets, Schedules, etc.

☒ Facility Internal Investigation Reports

☒ Personnel Records/Background Check, etc.

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Five

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 reporter(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact reporter, 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: Attempted with both clients

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Four

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Seven

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: 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
☒ Personal Care
☒ Nursing Services
☒ Infection Control
☒ Medication Pass
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Meals
☒ Facility Tour
☒ Other: medication storage

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 storage

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Duluth Police Department

Saint Louis County Attorney

Duluth City Attorney

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 7015 3010 0001 4648 6132

December 22, 2017

Ms. Char Johnson, Administrator
Westwood Of Duluth
925 Kenwood Avenue
Duluth, MN 55811

RE: Complaint Number HL20935006 and HL20935007

Dear Ms. Johnson:

A complaint investigation (#HL20935006 and HL20935007) of the Home Care Provider named above was completed on November 27, 2017, for the purpose of assessing compliance with state licensing regulations. At the time of the investigation, the investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these regulations. These state licensing orders are issued in accordance with Minnesota Statutes Sections 144A.43 to 144A.482.

State licensing orders are delineated on the attached State Form. The 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by."

A written plan for correction of licensing orders is not required. Per Minnesota State Statute 144A.474 Subd. 8(c), the home care provider must document in the provider's records any action taken to comply with the correction order. A copy of this document of the home care provider's action may be requested at future surveys.

A licensed home care provider may request a correction order reconsideration regarding any correction order issued to the provider. The reconsideration must be in writing and received within 15 calendar days. Reconsiderations should be addressed to:

Renae Dressel, Health Program Rep. Sr
Home Care Assisted Living Program
Minnesota Department of Health
P.O. Box 3879
85 East Seventh Place
St. Paul, MN 55101

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Matthew Heffron

Matthew Heffron, JD, NREMT
Health Regulations Division
Supervisor 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

MLH

Enclosure

cc: Home Health Care Assisted Living File
Saint Louis County Adult Protection
Office of Ombudsman for Long Term Care
MN Department of Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20935	A. BUILDING: _____ B. WING _____	C 11/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD OF DULUTH	925 KENWOOD AVENUE DULUTH, MN 55811

(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(s) has been 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 October 3 and 4, 2017, a complaint investigation was initiated to investigate complaint #HL20935006 and HL20935007 . At the time of the survey, there were 46 clients that were receiving services under the comprehensive license. The following correction order is issued. 144A.44 Subd. 1 (14) is issued related to HL20935006	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 144A.474 SUBDIVISION 11 (b)(1)(2)	
0 325 SS=E	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 observation, interview and document review, the licensee failed to ensure clients were free from maltreatment (financial exploitation) when clients' prescription medications were stolen for two of six clients (C1, C2) reviewed. 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 pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: C2's medical record was reviewed. C2's service plan dated December 6, 2016, included assistance with medication administration. C2's cognitive exam dated November 3, 2016 indicated severe cognitive impairment. C2's physician orders dated July 18, 2017 indicated C2 was ordered Tramadol 50 milligrams (mg) twice a day, one tab in the morning and two tabs at bedtime. During an on-site visit on October 4, 2017, the licensee medication storage was observed. The	0 325		

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0 325	Continued From page 2 licensee had a locked medication room on each unit. The nurses were the only staff with access to the medication room. On the counter, set-up pill boxes were stored for each client. Licensed practical nurse (LPN)-L explained two pill boxes were set-up by the nurse at a time, each filled with a week of medications. One pill box was stored in the medication room and the other placed in a locked cabinet in each client's room for the resident assistants (RA) to administer. C2's bottle of Tramadol was stored in the medication room's narcotic lock box and logged in the narcotic book. C2's scheduled Tramadol was set up in the pill boxes by the nurse. The narcotic log book indicated on August 7, 2017 (Monday) at 5:10 p.m., LPN-C set up 31 tabs of Tramadol. The incident report dated August 21, 2017 indicated on August 7, 2017 RA-H observed during C2's evening medication pass, missing Tramadol from the Wednesday and Thursday slot of the pill box (total of six tabs). RA-H reported the missing medication to LPN-C and had seen RA-I in C2's room. The licensee planned to monitor RA-I's behavior more closely. The staff schedule dated August 7, 2017 indicated RA-I was not assigned to C2's unit and was assigned to a unit on the first floor. C2's room was located on the second floor unit. The narcotic log book indicated on August 7, 2017 at 6:44 p.m., LPN-C signed out six tabs of Tramadol on the narcotic log to replace the missing six tabs in the pill box. The narcotic log book indicated on August 21, 2017 (Monday) at 3:40 p.m., registered nurse	0 325		

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0 325	Continued From page 3 (RN)-A completed a count of C2's Tramadol. During an interview on October 4, 2017 at 1:25 p.m., RN-A stated client pill boxes were stored in a each client's room in a locked cabinet. The resident assistants had keys to open the cabinets to administer medications from the pill box. However, the keys were universal, therefore the keys could open any client's cabinet throughout all four units of the licensee. RN-A stated she instructed RA-H to immediately report if RA-I was observed in C2's room. The staff schedule dated August 21, 2017 indicated RA-I again was not assigned to C2's unit and was assigned to a unit on the first floor. The incident report dated August 21, 2017, indicated RA-H immediately called the nurses when she witnessed RA-I leaving C2's room. LPN-C and RN-A found six tabs of Tramadol missing from C2's pill box in his room, from the Wednesday and Thursday slot. The narcotic log book indicated on August 21, 2017 at 4:50 p.m., LPN-C signed out six tabs of Tramadol to replace the missing tabs from C2's pill box. The incident reported dated August 21, 2017, indicated a drug diversion investigation was initiated. On September 3, 2017, RA-I was terminated. During an interview on November 21, 2017 at 10:10 a.m., RA-G stated she worked on C2's unit with RA-H frequently. RA-I was seen coming from C2's room and RA-I said she was just visiting with him. RA-G stated she questioned the nurse why RA-I was on the unit when she was assigned to	0 325		

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0 325	Continued From page 4 work on a until downstairs. C2's Tramadol were found missing after RA-I left the unit. C1's medical record was reviewed. C1's service plan dated February 13, 2017 included assistance with medication administration. C1's cognitive exam dated February 13, 2017 indicated severe cognitive impairment. C1's admission orders dated February 13, 2017 indicated C2 was ordered Silvadene one percent cream to be applied to the lower extremities twice a day with dressing changes. A form titled "Medication Cost Not Covered By Insurance" dated March 13, 2017 indicated C1's out-of-pocket cost for the Silvadene cream was $101.78. C1's pharmacy delivery record indicated on May 31, 2017, C1's silvadene cream was delivered to the facility. The licensee incident reported dated June 13, 2017 indicated C1's new jar of Silvadene cream was missing when the nurse was going to complete C1's dressing change. A search was conducted and the jar was not found. On June 9, 2017, RA-D observed RA-I taking C1's Silvadene jar out of his room with some dressing supplies to treat a burn. RA-I stated she received the burn on the steam table at supper. RA-I did not complete a work injury form. During an interview on October 3, 2017 at 2:35 p.m., RA-E stated he saw RA-I burn herself when she lifted the steam table lid and had seen her sitting at the dining table dressing her burn with	0 325		

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0 325	Continued From page 5 Silvadene cream. RA-E stated he told RA-I to tell the nurse about her burn. RA-E stated he remembered seeing the new jar of Silvadene cream in C1's room that week. During an interview on October 3, 2017 at 2:45 p.m., RA-D stated RA-I walked over to C1's unit, although she was assigned to the other unit on second floor. RA-I said she burnt her hand and heard it was good for burns when she took C1's Silvadene cream out of his room. RA-I went back into C1's room after dressing her burn and RA-D stated thought she had put it back. During an interview on October 4, 2017 at 1:25 p.m., RN-A stated when RA-I was questioned she verified she had used the Silvadene cream, but did not steal it. RN-A stated RA-I was re-educated about not using client's medications and the licensee paid for a new jar of Silvadene cream for C1. The licensee policy titled Vulnerable Adult Reporting Investigation Policy dated 2016 indicated staff will be trained on the Vulnerable Adult Act and reporting policies. Occurrences of abuse, neglect and financial exploitation will be investigated by the RN. TIME PERIOD OF CORRECTION: 21 DAYS	0 325		