MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Vista Prairie at Windmill Pond	HL21855001	September 7, 2016
Facility Address:	**Time of Visit:**	**Date Concluded:**
715 Victor Street	12:00 p.m. - 4:00 p.m.	January 23, 2017
Facility City:	**Investigator's Name and Title:**	
Alexendria	Darin Hatch, Special Investigator	

State:	ZIP:	County:
Minnesota	56308	Douglas

☒ **Home Care Provider/Assisted Living**

Allegation(s):
It is alleged that a client was financially exploited when the alleged perpetrator (AP) took the client's medication.

☒ 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 the alleged perpetrator (AP) took the client's opioid medication.

The client received medication management from the home care provider according to the service agreement and service plan. The client had a physician's order for oxycodone oral solution (five milligrams / five milliliters), to be taken every four hours as needed for pain.

Document review and observations made during the on-site investigation revealed a nurse drew up liquid oxycodone in syringes for the client, and placed them in a double-locked medication storage cabinet. Keys were only available to on-duty unlicensed staff. The keys were always kept in the immediate possession of staff.

Interviews were conducted with two nurses. One nurse was setting up oral medication oxycodone syringes for the client, and noticed syringes s/he had previously set-up appeared to be lighter in color than the new syringes s/he just set up. The nurse examined the syringes s/he set up six days prior and noticed there were bubbles in the solution and the measurements were not as exact as his/her usual practice. The nurse said when s/he fills the syringes there are never any bubbles in the solution, they are precise measurements, they are verified by a second nurse, and s/he re-checks them each three to four times right before placing the syringes in the medication storage cabinet. The nurse shared his/her concerns with the second nurse, who also observed that the syringes set-up six days prior were lighter in color then the new syringes. The nurses suspected the newly hired AP had diverted the medication. The nurses discovered the AP, who was working as an unlicensed resident assistant, has a suspended nursing license, due to previous drug

diversions in Minnesota and another state; the AP had failed to disclose the suspended license to the home care provider. The nurses notified the police.

A police report indicated police were called to the facility for a suspected drug diversion. The police interviewed the AP and s/he admitted to taking the medications from the client. Police forwarded their investigation to the County Attorney for charging. The AP subsequently entered a guilty plea for Felony Controlled Substance Crime in the 5th Degree.

The AP was interviewed and admitted to taking medication from the client and diluting the solution in the syringes set up by the nurse. The AP stated s/he plead guilty to the Felony Controlled Substance charge.

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

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

Compliance:

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance 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 - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

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

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 9 - Financial exploitation

"Financial exploitation" means:

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

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

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

- ☒ Medical Records
- ☒ Care Guide
- ☒ Medication Administration Records
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Physician Orders
- ☒ Care Plan Records
- ☒ 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: 0

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

Specify: No additional records selected

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

○ Yes ◉ No ○ N/A

Specify: Located at another facility

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: No longer at the facility

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: 10

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 10

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:

☒ 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: _____

cc:

Health Regulation Division - Home Care & Assisted Living Program

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Alexendria Police Department

Douglas County Attorney

Alexendria City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21855	A. BUILDING: _____ B. WING _____	C 09/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE AT WINDMILL PONDS	715 VICTOR STREET ALEXANDRIA, MN 56308

(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 September 7, 2016, a complaint investigation was initiated to investigate complaint #HL21855001. At the time of the survey, there were 45 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 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 client (C1) reviewed was free from maltreatment when the client was financially exploited by a staff member who took medications from the client for her own use. This resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death) and is issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or that a situation has occurred only occasionally.) The findings include: C1's file was reviewed. C1 received comprehensive home care services, including medication management, and housing with services, from the licensee according to the service agreement and care plan dated April 21, 2016. C1 had a physician's order for oxycodone-oral solution- 5 milligrams (mg)/ 5 milliliters (ml), every four hours as needed for pain. Document review, interviews, and observations made during the onsite investigation revealed the licensed practical nurse (LPN)-C set-up syringes for C1 as needed in a double locked medication storage cabinet with two sets of keys available only to on-duty unlicensed professional staff. The	0 325		

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0 325	Continued From page 2 keys were always kept in the immediate possession of staff. Two staff members counted the medications in the storage cabinet at every shift change. The LPN stored the main bottle of the medication in the double locked nurses medication storage room with access only available to LPN-C and registered nurse (RN)-B. Document review and interviews during the onsite investigation revealed an undated and untitled document which indicated LPN-C was setting up oral medication oxycodone syringes for C1 on June 21, 2016 and noticed syringes that she had set-up on June 15, 2016 appeared to be lighter in color than the new syringes she set-up on June 21, 2016. LPN-C shared her concerns with RN-B. The document indicated LPN-C and RN-B observed the syringes set-up on June 15, 2016 were lighter in color from the syringes set-up on June 21, 2016. The document indicated the facility never had a concern with drug diversion in the past and suspected newly hired unlicensed personnel (ULP)-F had diverted the medication. RN-B checked the Minnesota Board of Nursing website because ULP-F's application information indicated ULP-F was formerly a LPN but ULP-F did not apply for an LPN position and was working as an ULP. RN-B discovered ULP-F's LPN license had been suspended by the Minnesota Board of Nursing for previous drug diversions in Minnesota and Kentucky but ULP-F failed to disclose that information to the Minnesota Board of Nursing and to the licensee. RN-B notified the police and the Minnesota Adult Abuse Reporting Center because she suspected C1 had been financially exploited by ULP-F. Interview with RN-B on September 7, 2016 at 2:24 p.m. revealed LPN-C came to her and said she was setting up oral medication oxycodone	0 325		

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0 325	Continued From page 3 syringes for C1 on June 21, 2016 and noticed syringes that she had set-up on June 15, 2016 appeared to be lighter in color than the new syringes she set-up on June 21, 2016. RN-B looked at the syringes and agreed the syringes from June 15, 2016 were not as deep pink as the syringes from June 21, 2016. She also noticed the amount was not exact at 5 ml and there were bubbles in the syringe. RN-B said LPN-C is very precise with the set-up process, and RN-B therefore suspected the syringes had been tampered with. RN-B said the facility never had a concern with drug diversion in the past and suspected newly hired ULP-F. RN-B checked the Minnesota Board of Nursing website because ULP-F's application information indicated ULP-F was formerly a LPN but ULP-F did not apply for a LPN position and was working as a ULP. RN-B discovered ULP-F's LPN license had been suspended by the Minnesota Board of Nursing for previous drug diversions in Minnesota and Kentucky but ULP-F failed to disclose that information to the Minnesota Board of Nursing and to the licensee. RN-B notified the police and the Minnesota Adult Abuse Reporting Center because she suspected C1 had been financially exploited by ULP-F. Interview with LPN-C on September 7, 2016 at 2:42 p.m. revealed she was setting up C1's syringes for oral medication oxycodone on June 21, 2016 and noticed the syringes she filled for C1 on June 15, 2016 were not as deep pink as the syringes from June 21, 2016. She said when she fills the syringes there are never any bubbles, they are very exact and precise measurements, they are verified by RN-B, and she re-checks them each three to four times right before placing the syringes in the double locked medication storage cabinet for the ULP's to administer the	0 325		

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0 325	Continued From page 4 medication to C1 as needed. LPN-C said she shared her concerns with RN-B. A police report dated dated June 21, 2016 indicated police were called to the facility for a suspected drug diversion. The report indicated police interviewed ULP-F and she admitted to taking the suspected medications from C1. Police forwarded their investigation to the County Attorney for charging A letter from the County Attorney's office dated August 2, 2016 indicated ULP-F entered a guilty plea for Felony Controlled Substance Crime in the 5th Degree. A policy titled "Home Care Bills of Rights" indicated on page one that all clients and staff receive a copy of the Minnesota Home Care Bill of Rights and "all staff receive training about the bill of rights and are expected to adhere to these rights." A policy titled "Controlled Substances/Schedule II Drugs" indicates on page one "this agency will take all reasonable precautions to eliminate the theft, diversion or misuse of controlled substances and will comply with requirements regarding the safe storage and disposal of these drugs." TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 325		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
H21855 Y1	A. Building B. Wing Y2	1/5/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 00325 Reg. # 144A.44, Subd. 1(14) LSC	Correction Completed 01/05/2017	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
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/26/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: RSH712