Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	**Report Number:**	**Date of Visit:**
Southview Senior Living	HL24035002	June 12, 2017
Facility Address:	**Time of Visit:**	**Date Concluded:**
1984 Oakdale Avenue	9:00 a.m. to 3:00 p.m.	September 15, 2017
Facility City:	**Investigator's Name and Title:**	
West Saint Paul	Meghan Schulz, RN, Special Investigator and Matthew Heffron, NREMT, Special Investigator	
State: / **ZIP:** / **County:**		
Minnesota / 55118 / Dakota		

☒ **Home Care Provider/Assisted Living**

Allegation(s):
It is alleged that a client was financially exploited when staff/alleged perpetrator (AP) admitted to swapping out oxycodone with metoprolol in a drug tray. The AP refused to take a drug test and admitted to having an oxycodone addiction and taking the oxycodone for personal 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 is substantiated. The alleged perpetrator (AP) admitted to taking between four to six oxycodone tablets (an opioid pain medications) from the client.

The client received services from a provider licensed as a comprehensive home care provider. The services the client received including medication management.

The missing oxycodone was discovered during medication set-up by a licensed practical nurse. The client did not miss any doses of the medication.

During an interview, facility management said when the missing oxycodone was discovered, random drug testing of employees was initiated. The AP admitted to having an addiction to oxycodone and that s/he would fail a drug test. The AP's employment at the facility was terminated.

The police were contacted and are still investigating.

During an interview, the AP admitted to taking the oxycodone from the client.

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 received training on the policies.

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

Compliance:

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

State licensing orders were issued: ☒ Yes ☐ No

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

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:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 9 - Financial exploitation

"Financial exploitation" means:

(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:

(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or

(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.

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

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

(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;

(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or

(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

(c) Nothing in this definition requires a facility or caregiver to provide financial management or supervise financial management for a vulnerable adult except as otherwise required by law.

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] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Service Plan

Other pertinent medical records:

- [x] Police Report

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Four

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: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Six

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Six

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:

☒ Nursing Services
☒ Call Light
☒ Infection Control
☒ Medication Pass
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Restorative Care
☒ Facility Tour
☒ Injury
☒ Incontinence

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

The Office of Ombudsman for Long-Term Care

West Saint Paul Police Department

Dakota County Attorney

West Saint Paul 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
	H24035	A. BUILDING: _____ B. WING _____	C 08/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW SENIOR LIVING	1984 OAKDALE AVENUE LILYDALE, MN 55118

(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 June 12, 2017, a complaint investigation was initiated to investigate complaint #HL24035002. At the time of the survey, there were 46 clients that were receiving services under the comprehensive license. 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		

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

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0 325	Continued From page 1 (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to ensure that one of one clients (C1) reviewed was free from maltreatment when the client was financially exploited by a staff when s/he took medications from the client for personal 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 record was reviewed. C1 received comprehensive home care services including medication management, according to a service agreement dated, January 10, 2017. During an interview on June 14, 2017, at 3:35 p.m., Licensed Practical Nurse (LPN-D) said that during her weekly medication set up for C1, she noticed the as needed (PRN) medication strip of oxycodone was not oxycodone but metoprolol. LPN-D said 6 oxycodone tablets were missing and that she reported it to the Director of Nursing (DON) who handled the situation from there. During an interview on June 12, 2017, at 1:43	0 325		

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0 325	Continued From page 2 p.m., DON-A said that she was notified of the missing medication by LPN-D. DON-A stated that she notified the regional director of nursing (DON-E) and they decided to do random drug testing on three employees, one of whom was the alleged perpetrator (AP-H). S/he stated that AP-H refused to do the drug test because s/he would fail. During an interview on June 12, 2017, at 1:08 p.m., residence director (RD-C) said s/he gave AP-H a ride home after s/he refused the drug test. RD-C states AP-H admitted to having an addiction to oxycodone and that s/he took C1's medication. During an interview on July 11, 2017, at 11:30 a.m., AP-H stated that s/he has been struggling with addiction and was having a weak moment and decided to take C1's oxycodone. AP-H states she took anywhere between four to six oxycodone from C1. A policy, dated February 1, 2014, and titled "Handling of Client Finances and Property", indicates a home care employee may not convert a client's property to his/her possession. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 325		
0 995 SS=F	144A.4792, Subd. 19 Storage of Medications Subd. 19. Storage of medications. A comprehensive home care provider providing storage of medications outside of the client's private living space must store all prescription medications in securely locked and substantially constructed compartments according to the	0 995		

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0 995	Continued From page 3 manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on document review and observation, the licensee failed to ensure all prescription medications are in a securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access for five of five clients, (C1), (C2), (C3), (C4) and (C5) 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). Findings include: C1's record was reviewed. C1 received comprehensive home care services including medication management, according to a service agreement dated, January 10, 2017. C2's record was reviewed. C2 received comprehensive home care services including medication management, according to service agreement dated, June 12, 2016. C3's record was reviewed. C3 received comprehensive home care services including medication management, according to a service agreement dated, July 31, 2013.	0 995		

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0 995	Continued From page 4 C4's record was reviewed. C4 received comprehensive home care services including medication management, according to a service agreement dated, November 8, 2016. C5's record was reviewed. C5 received comprehensive home care services including medication management, according to a service agreement dated, May 23, 2015. Observations on June 12, 2017 revealed that clients that receive medications management have their controlled subtances in a locked box in their room. Multiple staff members have access to the keys to unlock med boxes. The boxes for all five clients were observed, a lock was in place, but the investigator was able to slip hand in the box and grab out medications in all five boxes, without a key. A policy, dated June 1, 2014 and titled "Storage of Medications", indicates that medications managed by the home care provider shall be stored to prevent diversion of medications by clients or other who may have access to the medicatinos. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 995		