DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
PRNSC	HL25662006	September 18, 2017
Facility Address:	**Time of Visit:**	**Date Concluded:**
2740 American Blvd W STE 100	8:15 a.m. to 3:00 p.m.	October 5, 2017
Facility City:	**Investigator's Name and Title:**	
Bloomington	Earl Bakke, RN Special Investigator	

State:	ZIP:	County:
Minnesota	55431	Hennepin

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was financially exploited when the alleged perpetrator (AP) stole clients' checks and deposited in a Bank ATM. The amount of money stolen was $1,700.00

☒ 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 the preponderance of evidence, financial exploitation is substantiated when the alleged perpetrator (AP) stole checks and cashed them from three clients and cashed them for a total of $7,115.00.

Each client received services from the comprehensive home care provider for nurse monitoring and medication management and assistance.

A family member from one of the client's contacted law enforcement after discovering a fraudulent withdrawal from the client's checking account. A law enforcement officer obtained a copy of the fraudulent check and notified management of the client's residency. PRNSC Management showed the fraudulent check to a staff member who recognized the endorsement. The endorsement closely resembled the AP's signature. The staff member showed the law enforcement officer an employment record that the AP had signed and the signatures were a close resemblance. The law enforcement officer obtained a copy of the AP's bank transactions and learned that three other similar deposits were made. The law enforcement officer met with a registered nurse and discovered the similar transactions belonged to two other clients. All three clients, along with family members for each informed the law enforcement officer that all checks were stolen. One client had a check cashed in the early part of November 2016 for $1,415.00. A few days later, another client had a check cashed in the amount of $1,700.00. Several weeks later, a third client had a

check cashed in the amount of $1,500.00, and days later that same client had a second check cashed in the amount of $2,500.00. Each check was deposited into the AP's bank account.

Copies of all the fraudulent checks were obtained, and the endorsement signature on each check closely resembles the signature of the AP's signed employment documents.

The photograph of the person who deposited each check at the ATM matched the AP's driver's license picture.

During an interview with the AP, she denied stealing and depositing any of the checks into her account. The AP said someone stole her debit card from work and must have deposited the checks.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☐ Neglect ☒ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☐ Facility is responsible for the

☐ Abuse ☐ Neglect ☒ Financial Exploitation. This determination was based on the following:

The Facility has policies in place regarding theft. The AP signed an employment document that clearly states property theft of any kind will not be tolerated. Taking of a resident, facility, or employee property is theft and will be treated appropriately. A background check was completed on the AP and indicated clear to work.

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

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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:

(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
- ☒ Assessments
- ☒ Facility Incident Reports
- ☒ Activities Reports

☒ Service Plan

Other pertinent medical records:

☒ Police Report

Additional facility records:

☒ Staff Time Sheets, Schedules, etc.

☒ Personnel Records/Background Check, etc.

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Two

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: Two of the three were

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: Two of the three

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Seven

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Four

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:

☒ Dignity/Privacy Issues

☒ Safety Issues

☒ Facility Tour

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Anoka Police Department

Anoka City Attorney

Anoka County Attorney

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 70151660000041498341

December 15, 2017

Ms. Charie Devolties, Administrator
PRNSC
2740 American Blvd W
Bloomington, MN 55431

RE: Complaint Number HL25662006

Dear Ms. Devolties :

A complaint investigation (#HL25662006) of the Home Care Provider named above was completed on November 3, 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,

Mike Kaehler
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) 201-4181 Fax: (651) 281-9796

MK

Enclosure

cc: Home Health Care Assisted Living File
Anoka County Adult Protection
Office of Ombudsman
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
	H25662	A. BUILDING: _____ B. WING _____	C 11/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRNSC	2740 AMERICAN BLVD W BLOOMINGTON, MN 55431

(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, these correction orders have 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 September 18, 2017, a complaint investigation was initiated to investigate complaint #HL25662006. At the time of the survey, there were 78 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=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 document review and interview, the licensee failed to ensure that a client was free from maltreatment (financial exploitation) for three of three clients, (C1, C2, and C3), reviewed when a staff member stole personal checks from C1, C2, and C3 and cashed each for a total of $7,115.00. The violation occurred as a level 2 violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death) and 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). Findings include: C1's medical record was reviewed. C1's service agreement, dated March 1, 2016, indicated C1 received services for management and monitoring by a registered nurse (RN) / licensed practical nurse (LPN) and medication management. C2's medical record was reviewed. C2's service agreement, dated July 10, 2017, indicated C2 received services for medication management, dressing, grooming, and toileting.	0 325		

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0 325	Continued From page 2 C3's medical record was reviewed. C3's service agreement, dated June 1, 2017, indicated C3 received services for registered nurse monitoring and medication management. RA-G's employee file was reviewed. A form titled Employee Expectations and signed by RA-G, undated, indicated property theft of any type would not be tolerated, and that taking of resident, facility, or employee property was theft and would be treated appropriately. A law enforcement report with an original date of January 9, 2017, indicated RA-G stole a check from C1 and deposited it on December 7, 2016 into her personal account for the amount of $1,700.00. The report indicated RA-G stole a check from C2 and deposited it on November 28, 2016 for the amount of $1,415.00. The report also indicated RA-G stole two checks from C3. One of C3's checks was deposited on December 1, 2016 in the amount of $1,500.00 and the second check was deposited on December 6, 2016 in the amount of $2,500.00. The law enforcement report indicated that RA-G's picture had been obtained from the ATM camera for each of the dates and times the checks were deposited and it matched her driver's license picture. The endorsement signature on each fraudulent check closely resembled RA-G's signature found on her employment paperwork. Law enforcement were filing felony criminal charges on RA-G. During an interview with a registered nurse (RN)-B, on September 18, 2017 at 3:07 p.m., she said a staff member recognized the endorsement signature on C1's fraudulent check and provided RA-G's name and employment paperwork with signatures to law enforcement. RA-G's	0 325		

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0 325	Continued From page 3 employment was terminated based on the allegations. A policy and procedure titled Vulnerable adult reporting and investigation policy, dated July 2015 indicated Financial exploitation in a breach of fiduciary obligation, a person engages in unauthorized expenditure of funds which is likely to be detrimental to the VA (vulnerable adult) or fails to use the VA's financial resources to provide food, clothing, shelter, healthcare, therapeutic conduct or supervision of the VA and the failure results or is likely to result in detriment to the VA. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 325		
02015 SS=E	626.557, Subd. 3 Timing of Report Subd. 3. Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or	02015		

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02015	Continued From page 4 (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.	02015		

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02015	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to immediately report to the common entry point when they had reason to believe maltreatment (financial epxloitation) occurred for 2 of 3 clients (C2 and C3) reviewed, when checks and money were stolen from the clients. This occurred at a level 2 violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death) and 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). Findings include: C1's medical record was reviewed. C1's service agreement, dated March 1, 2016, indicated C1 received services including monitoring by a registered nurse (RN) / licensed practical nurse (LPN) and medication management. C2's medical record was reviewed. C2's service agreement, dated July 10, 2017, indicated C2 received services for medication management, dressing, grooming, and toileting. C3's medical record was reviewed. C3's service agreement, dated June 1, 2017, indicated C3 received services for registered nurse monitoring and medication management. A police report, dated January 26, 2017, indicated a law enforcement officer obtained copies of an	02015		

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02015	Continued From page 6 unlicensed personnel (ULP)-G's bank account transactions. The law enforcement officer discovered two other people (C2 and C3) had checks stolen and fraudulently deposited into ULP-G's account. The law enforcement officer notified the executive director (ED)-A of the client's facility. During an interview on September 18, 2017, at 2:40 p.m., ED-A said that January 17, 2017, a law enforcement officer notified her and a registered nurse who previously worked for the licensee, that C2 and C3 had checks stolen from them. ED-A said she assisted in notifying client's family members and beginning an internal investigation. ED-A said that the nurse said she would be filing the reports to the common entry point. ED-A said she thought the vulnerable adult maltreatment reports had been filed. During an interview on September 18, 2017, at 3:07 p.m., registered nurse (RN)-B said that she was not aware if the common entry point reports had been made, because the incidents occurred before her employment. RN-B said the previous registered nurse and the licensee's human resources (HR) department handled the incidents. The Facility did not report the allegation to the common entry point. A policy and procedure for the licensee, titled Vulnerable Adult Reporting and Investigation Policy, dated July 1, 2015, indicated that in accordance with State and Federal vulnerable adult laws, our agency's employees will report any suspected maltreatment (abuse, neglect or financial exploitation as defined in MN Statutes 626.5572) of our home care clients.	02015		

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