MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Apple Valley Villa	HL25804005	January 27, 2017
Facility Address:	**Time of Visit:**	**Date Concluded:**
14610 Garrett Avenue	8:15 a.m.-3:00 p.m.	April 6, 2017
Facility City:	**Investigator's Name and Title:**	
Apple Valley	Kathleen Smith, DNP, RN, Special Investigator	

State:	ZIP:	County:
Minnesota	55124	Dakota

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was exploited when the alleged perpetrator took narcotic medications from the client's apartment.

☒ 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 the alleged perpetrator (AP) took a client's oxycodone and tramadol tablets.

The client began receiving services in 2012. The client was independent with medications and did not receive any medication management services from the home care provider. The client was alert, oriented, and without confusion.

The client notified administration of a concern that medications were missing. With the client's permission, a camera was placed in the client's bedroom to monitor the medications on the bedside table. Two days later, administration reviewed the video footage and observed the AP opening medication bottles, removing tablets, and placing the medications in her pocket. Administration reviewed the staff scheduled and noted the AP was not assigned to provide care to the client that day. The AP had approached the staff member assigned and offered to care for the client that day.

A police report indicated that after law enforcement reviewed the video footage, a police officer spoke with the AP, and found tablets in the AP's pocket. These tablets included some that were consistent with the tablets which were missing from the client's apartment, as well as other substances for which the AP did not have a prescription. The AP denied taking the medications. The police department forwarded their findings to the county attorney for charging.

The AP declined to be interviewed.

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 had policies in place regarding financial exploitation. The alleged perpetrator was provided education and training regarding financial exploitation. The alleged perpetrator signed the facility "Standard of Conduct" document which indicated tasks will be performed in an ethical way.

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:

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:

- [x] Medical Records
- [x] Assessments
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Service Plan

Other pertinent medical records:

- [x] Police Report

Additional facility records:

- [x] Personnel Records/Background Check, etc.
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: none

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: hospitalized

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: _____

Did you interview additional residents? ○ Yes ◉ No

Total number of resident interviews: _____

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: Called, declined to interview

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:

☒ 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

Apple Valley Police Department

Dakota County Attorney

Apple Valley 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
	H25804	A. BUILDING: _____ B. WING _____	C 01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLA	14610 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 are 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 January 27, 2017, a complaint investigation was initiated to investigate complaint #HL25804005. At the time of the survey, there were 73 clients 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/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." 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/RULES.	
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: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms	0 325		

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0 325	Continued From page 1 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 interview and document review, the licensee failed to ensure that a client was free from maltreatment (financial exploitation), when staff was found possessing medications belonging to C1. 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 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 began receiving services March 1, 2012, with diagnoses that included Congestive Heart Failure, Myocardial Infarction, and History of Stroke. An assessment dated January 11, 2016, noted C1 had left-sided weakness, and utilized a cane, walker, or scooter for mobility. Additionally, the assessment dated January 11, 2016, revealed C1 had chest pain with exertion, and had a pacemaker and defibrillator implanted. A review of the medication assessment document dated January 11, 2016, revealed C1 was independent with medications and medication administration, did not require any medication management services, was not taking narcotics at that time, and no interventions were in place to prevent diversion. A review of the Medication Management Plan for C1 dated January 11, 2016, revealed the family assisted with medication	0 325		

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0 325	Continued From page 2 set-up, monitoring of medication supplies, ordering refills, and management of pharmacy and prescriber communications. The Mental Status Questionnaire (MSQ), dated January 11, 2016, revealed C1 was alert and oriented, without confusion. A Care Plan Review dated November 28, 2016, for C1 revealed C1 was alert and oriented, and did not require medication services. During an interview on January 27, 2017 at 11:37 a.m., Registered Nurse (RN-C) stated that if a client was not receiving medication managment services, the unlicensed personnel (ULP) should not touch the client's medications. RN-C stated, during this same interview, that ULP-T was not assigned to provide any services to C1 on the day of the incident. During an interview on January 27, 2017 at 10:50 a.m., the Director of Housing Services (DOHS) stated C1 came to the office and expressed concern that medications were missing; the client had been prescribed controlled substances, which were stored in the client's room. C1 had a thirty day supply of these medications picked up on September 7, 2016, and on September 21, 2016, there was about a three day supply remaining. DOHS contacted law enforcement and the Director of Maintenance (DOM). The DOHS stated that, with permission of the client, a camera was placed in C1's bedroom to monitor the medications on the client's bedside table. The DOHS also stated that on September 23, 2016, the video footage was reviewed and ULP-T was observed opening bottles, and placing something in a pocket. Additionally, the DOHS said ULP-T was scheduled as the bath aide on September 27, 2016, and C1 was not scheduled for a bath that day.	0 325		

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0 325	Continued From page 3 The DOM was interviewed on January 27, 2017 at 12:13 p.m. and stated that upon viewing the video footage, the DOM observed ULP-T going through medications in C1's room, and the DOM then contacted the DOHS. Review of the police report revealed that law enforcement was shown the video footage, and then approached ULP-T, and found narcotic medications on the person of ULP-T, for which ULP-T had no prescription. ULP-T was contacted on February 24, 2017 at 11:19, but did not provide any additional information. The facility Vulnerable Adult Policy revised September 2015, reveals clients have the right to be free from financial exploitation. The document Prevention of Resident Abuse, revised August 2016 reveals the facility will monitor policies, procedures, training programs and systems in order to prevent abuse. TIME PERIOD FOR CORRECTION: TWENTY-ONE (21) DAYS	0 325		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 18, 2017

Ms. Andrea Nye, Administrator
Apple Valley Villa
14610 Garrett Avenue
Apple Valley, MN 55124

RE: Complaint Number HL25804005

Dear Ms. Nye :

On August 15, 2017 an investigator of the Minnesota Department of Health, Office of Health Facility Complaints completed a re-inspection of your facility, to determine correction of orders found on the complaint investigation completed on January 25, 2017 with orders received by you on March 4, 2017. At this time these correction orders were found corrected and are listed on the attached State Form.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Please feel free to call me with any questions.

Sincerely,

Matthew Heffron

Matthew Heffron, JD, NREMT
Health Regulations Division
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

MH/ja
Enclosure

cc: Home Health Care Assisted Living File
Dakota County Adult Protection
Office of Ombudsman
MN Department of Human Services