Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Autumn Grace	HL25816011, HL25816012, HL25816013, HL25816014, HL25816015, HL25816016, HL25816017	August 22 and 23, 2017

Facility Address:
118 Raven Court

Facility City:	Time of Visit:	Date Concluded:
Mankato	9:00 a.m to 5:00 p.m. & 9:30 a.m to 2:00 p.m.	September 15, 2017

State:	ZIP:	County:	Investigator's Name and Title:
Minnesota	56011	Blue Earth	Darin Hatch, Special Investigator

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that several clients were financially exploited when a staff member, alleged perpetrator (AP), took the client's narcotic medications for their own 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-drug diversion is substantiated. The alleged perpetrator (AP) took narcotic medications from five clients on five separate occasions. The AP took 345 tablets of hydrocodone/acetaminophen 10/325 milligrams (mg), 27 tablets of oxycodone 5 mg, 10 patches of fentanyl 100 micro-grams/hour (mcg/hr), 5 patches of fentanyl 50 mcg/hr, 104 tablets of tramadol 50 mg, 30 tablets of 1 mg lorazepam, and 39 tablets of 0.5 mg lorazepam.

All clients received medication management services from a provider licensed as a comprehensive home care provider according to service agreements. All clients had physician's orders for controlled substance medications.

Surplus client medications were taken on five separate occasions in June and July. The facility installed a video camera after the second incident and three of the five thefts were caught on video surveillance cameras. After each occasion, staff called the police, conducted an internal investigation, and turned over evidence including video footage to police.

The medications were surplus supplies awaiting placement into the central storage medication cart. As the clients ran out of medications in the cart, nursing staff would refill the medications from the surplus medications. The surplus medications were stored in the locked nurse's station, in a locked cabinet, in a tool box. Initially, the tool box was not locked, but the facility added a lock. To access to the surplus medication, nursing staff and an on-duty staff member in each unit had keys. Admission to the buildings was only obtained by an access code.

During interviews, staff explained each incident and reviewed the video surveillance footage during the interview. Three staff members identified the AP as the person in the videos.

A police report indicated police conducted an investigation of each incident of theft. The report indicated the AP took narcotic medications from five clients in June and July. The police forwarded their findings to the county attorney for formal charges.

During an interview, the AP denied the allegation.

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'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 facility is also responsible for failing to implement medication management policies and procedures, required by law, to ensure security and accountability for controlled substance medications they managed.

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: [x] 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: [x] 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: [x] 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;

(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.

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] Care Plan Records
- [x] Facility Incident Reports
- [x] ADL (Activities of Daily Living) Flow Sheets
- [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: None

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:

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: Seven

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Nine

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:

- [x] Medication Pass
- [x] Cleanliness
- [x] Dignity/Privacy Issues
- [x] Safety Issues
- [x] Meals
- [x] Facility Tour
- [x] 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: Damaged cabinet & provider licenses

cc:

Health Regulation Division - Home Care & Assisted Living Program

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Mankato Police Department

Blue Earth County Attorney

Mankato 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
	H25816	A. BUILDING: ____ B. WING ____	R-C **11/22/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GRACE	**118 RAVEN COURT MANKATO, MN 56001**

(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 A licensing order follow-up was completed on November 22, 2017 to follow up on correction orders issued related to complaint HL25816011, HL25816012, HL25816013, HL25816014, HL25816015, HL25816016, and HL25816017. Autumn Grace was found in compliance with state regulations.	{0 000}		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

November 29, 2017

Mr.. Dan Castleberry, Administrator
Autumn Grace
118 Raven Court
Mankato, MN 56001

RE: Complaint Number HL25816011, HL25816012, HL25816013, HL25816014, HL25816015, HL25816016, and HL25816017

Dear Mr. Castleberry:

On November 22, 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 September 8, 2017 with orders received by you on October 13, 2017. At this time these correction orders were found corrected and are listed on the attached State Form: Revisit Report.

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, 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
Blue Earth County Adult Protection
Office of Ombudsman for Long Term Care
MN Department of Human Services

Minnesota Department of Health

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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 August 22 and 23, 2017, a complaint investigation was initiated to investigate complaint #HL25816011, HL25816012, HL25816013, HL258160014, HL25816015, HL25816016, and HL25816017. At the time of the survey, there were 39 clients that were receiving services under the comprehensive license. The following correction orders are issued for case #HL25816011, HL25816012, HL25816013, HL258160014, HL25816015, HL25816016, and HL25816017.	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=F	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

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0 325	Continued From page 1	0 325		

(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, observations, and interviews, the licensee failed to ensure the right of five of five clients (C1, C2, C3, C4, and C5) reviewed to be free from financial exploitation-drug diversion when a staff member took controlled substance medications from all five clients on five separate occasions for their own personal use.

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 is 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). The findings include:

Observations made during the onsite investigation on August 22, 2017 at 9:30 a.m. revealed the facility had a double locked, central storage medication cart where active medications were dispensed from. Medications in the cart are double counted at every shift change by two staff. The building was locked and required an access code to enter and exit the facility.

Observations made during the onsite investigation on August 22, 2017 at 9:30 a.m. revealed a broken cabinet with the doors missing and obvious damage noted in the nurse's station

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0 325	Continued From page 2 where staff interviewed revealed a tool box used to be located in which surplus controlled substance medications waiting to be placed into the central storage cart when needed were stored prior to July 5, 2017. A photo of the damaged cabinet was taken. C1's record was reviewed. C1 received medication management services from the licensee according to a service agreement dated June 6, 2017. C1 had a physician's order for oxycodone 5 milligrams (mg) dated June 2, 2016. C2's record was reviewed. C2 received medication management services from the licensee according to a service agreement date May 9, 2017. C2 had a physician's order for hydrocodone/acetaminophen 10/325 mg dated June 16, 2017. C2 had a physician's order for fentanyl transdermal patch 100 micro-grams/hour (mcg/hr) dated May 31, 2017 and June 19, 2017. C3's record was reviewed. C3 received medication management services from the licensee according to a service agreement date May 10, 2017. C3 had a physician's order for lorazepam 0.5 mg dated May 18, 2017. C4's record was reviewed. C4 received medication management services from the licensee according to a service agreement date May 10, 2017. C4 had a physician's order for lorazepam 1 mg dated January 12, 2017. C5's record was reviewed. C5 received medication management services from the licensee according to a service agreement date. C5 had a physician's order for fentanyl transdermal patch 50 mcg/hr. dated May 12, 2017. C5 had a physician's order for tramadol 50	0 325		

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0 325	Continued From page 3 mg dated June 7, 2017. An untitled document obtained during the onsite investigation on August 22, 2017 indicated the following clients had the following medication taken on the following dates: June 8th, 2017; C2-2 cartridges of 10/325 mg hydrocodone, 31 pills each June 9th, 2017; C2-4 cartridges 10/325 mg hydrocodone, 31 pills each, C1-oxycodone 5 mg, 27 pills June 17, 2017; C2-2 cartridges of 10/325 mg hydrocodone, 31 pills each June 19, 2017; C2-5 cartridges of 10/325 mg hydrocodone, 31 pills each, C2 fentanyl patches 100 mcg/hr, 5 patches. July 5, 2017; C2- 1 cartridges of 10/325 mg hydrocodone 4 pills total, C2 fentanyl patches 100 mcg/hr, 1 box containing 5 patches. C5- fentanyl patches 50 mcg/hr, 1 box containing 5 patches, 4 cartridges tramadol 50 mg (104 pills) C4-1 cartridge 1 mg lorazepam 30 pills. C3-1 cartridge 0.5 mg lorazepam 19 pills & 1 cartridge 0.5 mg lorazepam 20 pills During interview on August 23, 2017 at 12:38 p.m. executive director (ED)-F said medications are dispensed to clients from a double locked, centrally stored medication cart. She said staff double count the medications daily at shift change. She said no medication was missing from that cart.	0 325		

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0 325	Continued From page 4	0 325		

ED-F said surplus controlled substance medications waiting to be placed into the central storage cart when needed were stored in the locked nurse's station prior to July 5, 2017. The medications had a count sheet with a rubber band attached to them and were stored in a toolbox, unlocked, in a cabinet that was locked that was attached to the wall. ED-F said the cabinet doors were secured with a cable and a padlock. Only nursing staff had a key along with one staff key ring in the memory care unit and the vent unit. ED-F said she realized after June 9, 2017 a person could slide their hand past the locked cabinet door and access the unlocked toolbox in the cabinet so she put a lock on the toolbox on June 9, 2017. ED-F said she realized on June 17, 2017 that a person could still slide their hand past the locked cabinet door and access the now locked toolbox so she had maintenance staff shorten the length of the cable on the cabinet so a hand would not be able to be slid past the locked cabinet door. ED-F said in hindsight she should have had a better system in place to prevent the ability of a person to slide their hand past the cabinet doors and access the toolbox.

ED-F said she was notified on June 8, 2017 by registered nurse (RN)-G that C2 was missing some medication from the cabinet in the nurse's station. ED-F said she called a meeting on June 9, 2017 to investigate C2's missing medications. ED-F said she discovered the following medications missing during her investigation: C2-6 cartridges of 10/325 mg hydrocodone, 31 pills each, 186 pills total. C1- oxycodone 5 mg, 27 pills

ED-F said staff were not counting the medications in the toolbox in the cabinet regularly but only

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0 325	Continued From page 5 when they went in there to refill the medication cart. ED-F called police and the Minnesota Adult Abuse Reporting Center (MAARC). ED-F said she changed the access code to the facility, changed the lock on the cabinet, placed a lock on the tool box in the cabinet, and placed a camera on the cabinet. ED-F said she was notified on June 17, 2017 by RN-H that medications were again missing from the toolbox in the cabinet, in the nurse's station. ED-F called the police and the MAARC. ED-F said she changed the door codes again, tightened the door gap on the cabinet, viewed the video, gave the video to police, and conducted an investigation. ED-F said she discovered the following medications missing during her investigation: C2-2 cartridges of 10/325 mg hydrocodone, 31 pills each, 62 pills total. ED-F said she was notified on June 19, 2017 by RN-H that medications were again missing from the toolbox in the cabinet, in the nurse's station. ED-F called the police and the MAARC. ED-F said she changed the door codes again, moved the camera to a better location, viewed the video, gave the video to police, and conducted an investigation. ED-F said she discovered the following medications missing during her investigation: C2-5 cartridges of 10/325 mg hydrocodone, 31 pills each-155 pills total and C2 fentanyl patches 100 mcg/hr, 5 patches. ED-F said she was notified on July 5, 2017 by RN-H that medications were again missing from the toolbox in the cabinet, in the nurse's station. RN-H told ED-F the cabinet doors had been ripped off the hinges and the entire tool box was gone. ED-F called the police and the MAARC.	0 325		

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0 325	Continued From page 6	0 325		

ED-F viewed the video, gave the video to police, and conducted an investigation. ED-F said she discovered the following medication missing during her investigation:
C2- 1 cartridges of 10/325 mg hydrocodone 4 pills total, C2 fentanyl patches 100 mcg/hr, 1 box containing 5 patches.
C5- fentanyl patches 50 mcg/hr, 1 box containing 5 patches, 4 cartridges tramadol 50 mg (104 pills)
C4-1 cartridge 1 mg lorazepam 30 pills.
C3-1 cartridge 0.5 mg lorazepam 19 pills & 1 cartridge 0.5 mg lorazepam 20 pills

During interview on August 23, 2017 at 12:38 p.m. ED-F reviewed video surveillance footage she provided from June 17, 2017 and identified RN-M as the person in the video who took the missing medications from the cabinet in the nurse's station on June 17, 2017.

During interview on August 23, 2017 at 12:38 p.m. ED-F reviewed video surveillance footage she provided from June 19, 2017 and identified RN-M as the person in the video who took the missing medications from the cabinet in the nurse's station on June 19, 2017. ED-F said the person in the video on June 19, 2017 is the same person in the video on June 17, 2017 and said that person is RN-M. ED-F said she showed the video to police and the police officer also identified the person in the video on June 17 and June 19, 2017 as RN-M.

During interview on August 23, 2017 at 12:38 p.m. ED-F reviewed video surveillance footage she provided from July 5, 2017. ED-F again identified RN-M as the person in the video along with another unknown person. ED-F said it appears in the video RN-M let the unknown person into the office while the unknown person

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0 325	Continued From page 7	0 325		

broke into the locked cabinet and took the tool box containing the controlled substance medications. ED-F said the person in the video is the same person in the videos on June 17, and June 19, 2017 and believes that person to be RN-M.

During interview on August 23, 2017 at 12:38 p.m. ED-F said she believes RN-M is the only person responsible for the theft of the controlled substance medications from June 8 to July 5, 2017. ED-F said RN-M had access to door codes, had access to keys, had the necessary knowledge of the narcotic system at the facility, and had knowledge of the overnight shift when the thefts occurred in conjunction with seeing the video surveillance footage.

During interview on August 23, 2017 at 11:33 a.m. business office manager (BOM)-C reviewed video surveillance footage she provided from June 17, 2017 and identified RN-M as the person in the video who took the missing medications from the cabinet in the nurse's station on June 17, 2017. BOM-C said she believes the person in the video is RN-M because of the physical characteristics of the person in the video and because RN-M had the access code to the building, had access to the keys for the nurse's station and the cabinet, and had knowledge of where the controlled substance medications were located.

During interview on August 23, 2017 at 11:33 a.m. BOM-C reviewed video surveillance footage she provided from June 19, 2017 and identified RN-M as the person in the video who took the missing medications from the cabinet in the nurse's station on June 19, 2017. BOM-C said she believes the person in the video is RN-M because RN-M had the access code to the building, had

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access to the keys for the nurse's station and the cabinet, and had knowledge of where the controlled substance medications were located.

During interview on August 23, 2017 at 11:33 a.m. BOM-C reviewed video surveillance footage she provided from July 5, 2017 and identified RN-M as the person in the video who took the missing medications from the cabinet in the nurse's station on July 5, 2017. BOM-C said she believes the person in the video is RN-M . She also said she watched the video with the police officer and the police officer identified RN-M as the person in the video. BOM-C said she also used social media web pages to identify RN-M as the person in the videos.

During interview on August 23 at 9:51 a.m. owner (O)-A said she was notified by ED-F and BOM-C of the narcotic thefts and they investigated the thefts after each incident along with police. She said she watched all of the surveillance videos the facility had recorded and identified RN-M as the person in all of the videos as the person who took the narcotic medications from clients. O-A said she believes RN-M is the person in the videos and believes RN-M took the medications because there was no signs of forced entry at the main doors and RN-M had access to door codes, keys, and had knowledge of the narcotic storage system. O-A also said police investigated the incidents and also identified RN-M as the person in the videos and believe RN-M was the person responsible for the thefts. O-A said she also used social media web pages to identify RN-M as the person in the videos.

A police report dated June 10, 2017 with an identification number of 17-17204 indicates police conducted an investigation of each incident of

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0 325	Continued From page 9 theft that was reported to them by the licensee. The report indicates RN-M is the person responsible for the thefts of narcotic medications from C1, C2, C3, C4, and C5 that occurred at the facility between June 8 and July 5, 2017. The report indicates the police forwarded their findings to the county attorney for formal charges. A policy titled "Handling of Client's Finances and Property" dated January 27, 2015 indicates on page one client property may not be used by staff for personal use. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 325		
0 815 SS=E	144A.479, Subd. 7 Employee Records Subd. 7. Employee records. The home care provider must maintain current records of each paid employee, regularly scheduled volunteers providing home care services, and of each individual contractor providing home care services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification, if licensure, registration, or certification is required by this statute or other rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including	0 815		

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0 815	Continued From page 10 qualifications, responsibilities, and identification of staff providing supervision; (4) documentation of annual performance reviews which identify areas of improvement needed and training needs; (5) for individuals providing home care services, verification that required health screenings under section 144A.4798 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. Each employee record must be retained for at least three years after a paid employee, home care volunteer, or contractor ceases to be employed by or under contract with the home care provider. If a home care provider ceases operation, employee records must be maintained for three years. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to maintain records of annual performance reviews for two of four employees reviewed. 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 is issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are	0 815		

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0 815	Continued From page 11 involved, or the situation has occurred repeatedly but is not found to be pervasive). The findings include: Document review during the on-site investigation of the employee file for registered nurse (RN)-M revealed a date of hire of August 21, 2012. A request for annual performance reviews was made to the licensee but not provided. Document review during the on-site investigation of the employee file for nursing assistant (NA)-C revealed a date of hire of May 18, 2014. A request for annual performance reviews was made to the licensee but not provided. An e-mail dated August 28, 2017 at 9:01 a.m. from executive director (ED)-F indicated there was no 2016 performance evaluation for RN-M An e-mail dated August 29, 2017 at 4:50 p.m. from ED-F indicated there was no 2016 performance evaluation for NA-C. A policy titled "Performance Review policy" indicates on page one each supervisor will complete the annual performance review form for each employee they supervise and the supervisor will meet with employees annually to review the employees performance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 815		
0 900 SS=F	144A.4792, Subd. 1 Medication Management; Comprehensive Subdivision 1. Medication management services;	0 900		

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comprehensive home care license. (a) This subdivision applies only to home care providers with a comprehensive home care license that provide
medication management services to clients. Medication management services may not be provided by a
home care provider who has a basic home care license.

(b) A comprehensive home care provider who provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The
policies and procedures must be developed under the supervision and direction of a registered nurse,
licensed health professional, or pharmacist consistent with current practice standards and guidelines.

(c) The written policies and procedures must address requesting and receiving prescriptions for
medications; preparing and giving medications; verifying that prescription drugs are administered as
prescribed; documenting medication management activities; controlling and storing medications;
monitoring and evaluating medication use; resolving medication errors; communicating with the
prescriber, pharmacist, and client and client representative, if any; disposing of unused medications; and
educating clients and client representatives about medications. When controlled substances are

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being
managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance
with state and federal regulations and with subdivision 22.

This MN Requirement is not met as evidenced by:
Based on document review, observations, and interviews, the licensee failed to ensure the right of five of five clients (C1, C2, C3, C4, and C5) reviewed to be free from financial exploitation-drug diversion when a staff member took controlled substance medications from all five clients on five separate occasions for their own personal use.

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 is 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). The findings include:

Observations made during the onsite investigation on August 22, 2017 at 9:30 a.m. revealed the facility had a double locked, central storage medication cart where active medications were dispensed from. Medications in the cart are double counted at every shift change by two staff. The building was locked and required an access code to enter and exit the facility.

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Observations made during the onsite investigation on August 22, 2017 at 9:30 a.m. revealed a broken cabinet with the doors missing and obvious damage noted in the nurse's station where staff interviewed revealed a tool box used to be located in which surplus controlled substance medications waiting to be placed into the central storage cart when needed were stored prior to July 5, 2017. A photo of the damaged cabinet was taken.

C1's record was reviewed. C1 received medication management services from the licensee according to a service agreement dated June 6, 2017. C1 had a physician's order for oxycodone 5 milligrams (mg) dated June 2, 2016.

C2's record was reviewed. C2 received medication management services from the licensee according to a service agreement date May 9, 2017. C2 had a physician's order for hydrocodone/acetaminophen 10/325 mg dated June 16, 2017. C2 had a physician's order for fentanyl transdermal patch 100 micro-grams/hour (mcg/hr) dated May 31, 2017 and June 19, 2017.

C3's record was reviewed. C3 received medication management services from the licensee according to a service agreement date May 10, 2017. C3 had a physician's order for lorazepam 0.5 mg dated May 18, 2017.

C4's record was reviewed. C4 received medication management services from the licensee according to a service agreement date May 10, 2017. C4 had a physician's order for lorazepam 1 mg dated January 12, 2017.

C5's record was reviewed. C5 received medication management services from the

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licensee according to a service agreement date. C5 had a physician's order for fentanyl transdermal patch 50 mcg/hr. dated May 12, 2017. C5 had a physician's order for tramadol 50 mg dated June 7, 2017.

An untitled document obtained during the onsite investigation on August 22, 2017 indicated the following clients had the following medication taken on the following dates:

June 8th, 2017; C2-2 cartridges of 10/325 mg hydrocodone, 31 pills each

June 9th, 2017;
C2-4 cartridges 10/325 mg hydrocodone, 31 pills each,
C1-oxycodone 5 mg, 27 pills

June 17, 2017; C2-2 cartridges of 10/325 mg hydrocodone, 31 pills each

June 19, 2017; C2-5 cartridges of 10/325 mg hydrocodone, 31 pills each, C2 fentanyl patches 100 mcg/hr, 5 patches.

July 5, 2017;
C2- 1 cartridges of 10/325 mg hydrocodone 4 pills total, C2 fentanyl patches 100 mcg/hr, 1 box containing 5 patches.
C5- fentanyl patches 50 mcg/hr, 1 box containing 5 patches, 4 cartridges tramadol 50 mg (104 pills)
C4-1 cartridge 1 mg lorazepam 30 pills.
C3-1 cartridge 0.5 mg lorazepam 19 pills & 1 cartridge 0.5 mg lorazepam 20 pills

During interview on August 23, 2017 at 12:38 p.m., executive director (ED)-F said medications are dispensed to clients from a double locked, centrally stored medication cart. She said staff

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double count the medications daily at shift change. She said no medication was missing from that cart.

ED-F said surplus controlled substance medications waiting to be placed into the central storage cart when needed were stored in the locked nurse's station prior to July 5, 2017. The medications had a count sheet with a rubber band attached to them and were stored in a toolbox, unlocked, in a cabinet that was locked that was attached to the wall. ED-F said the cabinet doors were secured with a cable and a padlock. Only nursing staff had a key along with one staff key ring in the memory care unit and the vent unit. ED-F said she realized after June 9, 2017 a person could slide their hand past the locked cabinet door and access the unlocked toolbox in the cabinet so she put a lock on the toolbox on June 9, 2017. ED-F said she realized on June 17, 2017 that a person could still slide their hand past the locked cabinet door and access the now locked toolbox so she had maintenance staff shorten the length of the cable on the cabinet so a hand would not be able to be slid past the locked cabinet door. ED-F said in hindsight she should have had a better system in place to prevent the ability of a person to slide their hand past the cabinet doors and access the toolbox.

ED-F said she was notified on June 8, 2017 by registered nurse (RN)-G that C2 was missing some medication from the cabinet in the nurse's station. ED-F said she called a meeting on June 9, 2017 to investigate C2's missing medications. ED-F said she discovered the following medications missing during her investigation: C2-6 cartridges of 10/325 mg hydrocodone, 31 pills each, 186 pills total. C1- oxycodone 5 mg, 27

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pills

ED-F said staff were not counting the medications in the toolbox in the cabinet regularly but only when they went in there to refill the medication cart. ED-F called police and the Minnesota Adult Abuse Reporting Center (MAARC). ED-F said she changed the access code to the facility, changed the lock on the cabinet, placed a lock on the tool box in the cabinet, and placed a camera on the cabinet.

ED-F said she was notified on June 17, 2017 by RN-H that medications were again missing from the toolbox in the cabinet, in the nurse's station. ED-F called the police and the MAARC. ED-F said she changed the door codes again, tightened the door gap on the cabinet, viewed the video, gave the video to police, and conducted an investigation. ED-F said she discovered the following medications missing during her investigation:
C2-2 cartridges of 10/325 mg hydrocodone, 31 pills each, 62 pills total.

ED-F said she was notified on June 19, 2017 by RN-H that medications were again missing from the toolbox in the cabinet, in the nurse's station. ED-F called the police and the MAARC. ED-F said she changed the door codes again, moved the camera to a better location, viewed the video, gave the video to police, and conducted an investigation. ED-F said she discovered the following medications missing during her investigation: C2-5 cartridges of 10/325 mg hydrocodone, 31 pills each-155 pills total and C2 fentanyl patches 100 mcg/hr, 5 patches.

ED-F said she was notified on July 5, 2017 by RN-H that medications were again missing from

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0 900	Continued From page 18 the toolbox in the cabinet, in the nurse's station. RN-H told ED-F the cabinet doors had been ripped off the hinges and the entire tool box was gone. ED-F called the police and the MAARC. ED-F viewed the video, gave the video to police, and conducted an investigation. ED-F said she discovered the following medication missing during her investigation: C2- 1 cartridges of 10/325 mg hydrocodone 4 pills total, C2 fentanyl patches 100 mcg/hr, 1 box containing 5 patches. C5- fentanyl patches 50 mcg/hr, 1 box containing 5 patches, 4 cartridges tramadol 50 mg (104 pills) C4-1 cartridge 1 mg lorazepam 30 pills. C3-1 cartridge 0.5 mg lorazepam 19 pills & 1 cartridge 0.5 mg lorazepam 20 pills ED-F said nursing staff reordered the medications that were taken from the clients in June and July and no clients missed any medication doses. A policy dated February 2010 and 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	0 900		