MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Cottage Grove WP II LLC
6950 East Point Douglas Road S
Cottage Grove, Minnesota 55016
Washington County

Report #: HL27918001

Date: March 17, 2014

Date of Visit: March 4, 2014
Time of Visit: 8:45 a.m. – 1:00 p.m.

By: Lisa Jacobsen, R.N., Special Investigator

Type of Facility: ☐ Nursing Home ☐ HHA ☒ Home Care Provider/Assisted Living
☐ SLF ☐ ICF/IID ☐ Home Care
☐ Hospital ☐ Other: _____

☒ Facility Self Report ☐ Complaint

Allegation(s): **It is alleged** that financial exploitation occurred when a staff, alleged perpetrator (AP) took three tablets of a client's narcotic medication without permission.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☐ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☐ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☑ State Licensing Rules for Home Care (MN Rules Chapter 4668)

☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☐ Neglect ☑ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

A preponderance of evidence established that financial exploitation did occur. The AP took three tablets of OxyContin (a narcotic pain medication) that belonged to the client without the client's permission. In addition, the AP took one tablet of tramadol (an analgesic pain medication) that belonged to an additional client (name unknown), without the client's permission.

The client resided in a memory care facility, was identified as having severe cognitive impairment and required assistance from staff with medication administration. The client was identified as having pain and was administered OxyContin twice a day.

The clients' surplus narcotic medications that were not currently being used by clients were stored in the third drawer of a locked file cabinet, in a locked medication room. Two licensed nurses had keys that unlocked the file cabinet. The Unlicensed staff (ULP) did not have keys to this file cabinet. A surveillance video camera was set-up in the medication room and pointed directly at the locked file cabinet.

The two nurses counted the clients' narcotic medications in the file cabinet, locked the cabinet and left the facility at 4:30 p.m. The following morning at approximately 6:30 a.m., the two licensed nurses counted the narcotics in the file cabinet and noted that three OxyContin pills were missing from a prescription bottle that belonged to the client. The surveillance video was viewed and the AP was observed at approximately 9:53 p.m. (the time indicated on the video) to enter the medication room and attempt to unlock the file cabinet. When unsuccessful, the AP stepped out of the sight of the camera, returned within seconds and was observed to put something into the lock of the file cabinet. The AP was observed to open the second drawer of the file cabinet, closed it and opened the third drawer, moved around, then closed the drawer and left the medication room.

The police were contacted, and when the AP reported to work that day, the AP was arrested for theft and terminated from employment with the home care provider.

The police report indicated the AP stated s/he had a drug addiction and was addicted to pain killers. The AP stated the first theft took place right after being hired by the home care provider. The AP stated that sometime in September of 2013 s/he took one tramadol pill that belonged to another client. In addition, the AP admitted to the police that s/he took the three OxyContin pills that belonged to the client, that were noted to be missing when the narcotic medications were counted.

The AP was not interviewed by the investigator during the investigation at the advisement of her/his attorney.

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 govern the handling and control of narcotic medications and the consequences of theft from clients. The home care provider trained the AP on policies regarding financial exploitation and vulnerable adult protection. Despite agency policies and training the AP took two different clients' medications without their permission.

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 Licensing Rules for Home Care (MN Rules Chapter 4668) – Compliance Met
The facility was found to be in compliance with State Licensing Rules for Home Care (MN Rules Chapter 4668). No state licensing orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

State Statutes Chapters 144 & 144A – Compliance Met
The facility was found to be in compliance with State Statutes for Chapters 144 & 144A. No state licensing orders were issued.

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

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.

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;

The Investigation included the following:

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

☒ Medical Records	☐ Care Guide
☒ Medication Administration Records	☒ Treatment Sheets
☐ Facility Incident Reports	☒ Physician Progress Notes
☒ ADL (Activities of Daily Living) Flow Sheets	☐ Laboratory and X-ray Reports
☒ Physician Orders	☐ Social Service Notes
☒ Nurses Notes	☐ Meal Intake Records
☐ Activities Reports	☐ Weight Records
☐ Therapy and/or Ancillary Services Records	☒ Assessments
☐ Skin Assessments	☒ Care Plan Records

Other pertinent medical records:

☐ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☐ Death Certificate

☒ Police Report

Additional facility records:

☐ Resident/Family Council Minutes ☒ Personnel Records/Background Check, etc.

☒ Staff Time Sheets, Schedules, etc. ☒ Facility In-service Records

☒ Facility Internal Investigation Reports ☒ Facility Policies and Procedures

☐ Call Light Audits ☐ Other, specify: _____

Number of additional resident(s) reviewed: 4

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 complainant(s): ○ Yes ○ No ◉ N/A Specify: Facility Self-Report

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: 2

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

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 4

Physician interviewed: ○ Yes ◉ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ◉ No ○ N/A Specify: Declined at the advice of her/his attorney.

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:

☐ Wound Care	☐ Medication Pass	☐ Meals
☐ Personal Care	☐ Dignity/Privacy Issues	☐ Restorative Care
☐ Nursing Services	☐ Safety Issues	☒ Facility Tour
☐ Infection Control	☐ Cleanliness	☐ Injury
☐ Use of Equipment	☐ Transfers	☐ Incontinence
☐ Call Light	☒ Other: Verified narcotic count and narcotic 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: Narcotic storage/Medication Room

xc: Division of Compliance Monitoring - Licensing & Certification
Cottage Grove Police Department
Washington County Attorney
Cottage Grove City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H27918	A. BUILDING: _____ B. WING _____	C 03/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGE GROVE WP II LLC	6950 EAST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016

(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 complaint investigation was initiated to investigate case #HL27918001. No correction orders are issued.	0 000		