This document has been re-scanned to the MDH website.

The compliance revisit was completed on 10/6/16.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Stonecrest
8725 Promenade Lane
Woodbury, MN 55125
Washington County

Report#: HL27949001

Date: July 13, 2016

Date of Visit: April 15, 2016
Time of Visit: 10:30 a.m. – 3:00 p.m.

By: Darin Hatch, Special Investigator

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

☒ Facility Self Report ☐ Complaint

Allegation(s): **It is alleged** that three clients were financially exploited when a staff, alleged perpetrator (AP), stole the client's credit cards.

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 Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)
☐ 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:

Based on a preponderance of evidence financial exploitation did occur when the alleged perpetrator (AP) took four credit cards from three clients and used two of the credit cards. The thefts totaled $264.24 for Client #1, $166.21 for Client #2, and a stolen credit card from Client #3.

Client #1 received services from the home care provider for activities of daily living, housekeeping, laundry, and medication administration. Client #1 was alert and oriented to person, place, and time but was not interviewed at the request of the client's family. Client #2 received services from the home care provider for activities of daily living, housekeeping, laundry, and medication administration. Client #2 was deceased at the time of the onsite investigation. Client #3 received services from the home care provider for activities of daily living, housekeeping, laundry, and medication administration. Client #3 was alert to person but not place or time and when interviewed did not recall any details of the incident.

Interview with family of Client #2 revealed s/he was unable to locate two credit cards belonging to the client. S/he checked the client's credit card statements knowing the last time one of the credit cards was used was January 23, 2016. S/he discovered charges after that date that the client did not make because the client was at the hospital, subsequently on hospice care, and later deceased. S/he contacted the police and the home care provider.

Interview with the family of Client #1 revealed Client #1 spoke with the family of Client #2 and learned of Client #2's missing credit cards. Client #1 reported to family that s/he too was missing a credit card. The family of Client #1 checked Client #1's credit card statements and noticed charges that Client #1 would not have made at nearby retailers. The family member spoke with Client #1 and other family members and no one used the credit card at those retailers. The family of Client #1 contacted police and the home care provider.

Interview with the family of Client #3 revealed s/he was contacted by police after the AP admitted to taking Client #3's credit card from the client's clothing pocket while the AP was doing the client's laundry. The family member did not notice any unauthorized charges on the client's credit card.

A police report revealed family contacted police regarding some unauthorized credit card charges. Police obtained surveillance footage from retailers were the credit cards were used and brought the footage to facility

staff who identified the AP to police. Police interviewed the AP and s/he admitted to: taking and using Client #1's credit card in December on multiple occasions, taking two credit cards from Client #2 and using one of them in February on multiple occasions, and taking a credit card from Client #3. The police report indicated the following losses per client: Client #1-$264.24, Client #2-$166.21, Client #3-a credit card. Police issued a citation to the AP for theft of the four credit cards from all three clients and forwarded their investigation findings to the county attorney for formal charges for the unauthorized financial card transactions.

Attempts to interview the AP were unsuccessful.

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's acknowledgement 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 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 If no, specify: _____

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

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 Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

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
☒ Medication Administration Records
☒ Facility Incident Reports
☒ ADL (Activities of Daily Living) Flow Sheets
☒ Physician Orders
☐ Care Guide
☐ Treatment Sheets
☐ Physician Progress Notes
☐ Laboratory and X-ray Reports
☐ Social Service Notes

☒ Nurses Notes ☐ Meal Intake Records

☐ Activities Reports ☐ Weight Records

☐ Therapy and/or Ancillary Services Records ☒ Assessments

☐ Skin Assessments ☒ Care Plan Records

☒ Service Plan ☐ Other, specify: _____

Other pertinent medical records:

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

☒ Police Report ☐ Other, specify: _____

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: 1

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: All but client #1

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: 2

Physician interviewed: ○ Yes ◉ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Physician Assistant interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ◉ No ○ N/A Specify: Unable to contact

Attempts to contact: Date/time: 4-21-16/3:59 PM Date/time: 4-21-16/4:02 PM Date/time: 4-22-16/9:51 AM

If unable to contact was subpoena issued: ◉ Yes , date subpoena was issued 4-22-16 ○ 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: _____

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

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

Were photographs taken: ○ Yes ◉ No Specify: _____

xc: Health Regulation Division - Home Care & Assisted Living Program
The Office of Ombudsman for Long Term Care
Woodbury City Police Department
Washington County Attorney
Woodbury 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
	H27949	A. BUILDING: _____ B. WING _____	C 05/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONECREST	8725 PROMENADE LANE WOODBURY, MN 55125

(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 is 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 April 15, 2016, a complaint investigation was initiated to investigate complaint #HL27949001. At the time of the survey, there were 80 clients that were 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." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.	
0 325	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 three of three clients reviewed (C1), (C2), and (C3) were free from maltreatment when the clients were financially exploited by nursing assistant (NA)-F when she took the client's credit cards and used them for her own 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 services from the comprehensive home care provider for activities of daily living, medication administration, housekeeping, and laundry according to C1's service plan and care plans dated October 1, 2015. According to a nurses assessment dated February 11, 2016, C1 was alert and oriented to person, place, and time but was not interviewed at the request of the C1's family. C2's record was reviewed. C2 received services from the comprehensive home care provider for activities of daily living, housekeeping, laundry, and medication administration according to service plan and care plans dated January 21,	0 325		

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0 325	Continued From page 2 2016. According to a nurses assessment dated January 7, 2016, C2 was alert and oriented to person, place, and time at the time of the assessment. C2 was deceased at the time of the onsite investigation. C3's record was reviewed. C3 received services from the comprehensive home care for received services from the comprehensive home care provider for activities of daily living, housekeeping, laundry, and medication administration. According to a nurses assessment dated February 24, 2016, C3 was alert to person but not place or time and when interviewed on April 15, 2016 at 11:43 a.m. did not recall any details of the incident. Document review of NA-F's personnel file and time records revealed NA-F worked for the comprehensive home care provider from March 8, 2012 to March 4, 2016. ULP-F worked the following days in November: 1, 3, 4, 5, 6, 9, 11, 13, 15, 16, 17, 18, 19, 23, 26, 27,28, 29 2015; the following days in December: 1, 2, 3, 6, 7, 9, 10, 11, 12, 13, 15, 16, 17, 21, 23, 24, 25, 26, 27, 29, 30, 31, 2015; the following days in January: 2, 4, 6, 7, 8, 9, 10, 12, 13, 14, 18, 20, 21, 22, 23, 24, 26,27, 28, 30 2016; and the following days in February 1, 3, 4, 5, 6, 7, 9, 10, 11, 14, 15, 17, 18, 19, 20, 21, 23, 24, 25, 27, 29, 2016. Interview with family member (F)-E on April 22, 2016 at 2:24 p.m. revealed she was cleaning out C2 ' s apartment and was unable to locate two credit cards belonging to C2. She checked C2 ' s credit card statements knowing the last time one of the credit cards was used was January 23, 2016. She discovered charges after that date that C2 did not make because C2 was at the hospital, subsequently on hospice care, and later	0 325		

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0 325	Continued From page 3 deceased. She contacted the police and the comprehensive home care provider. Interview with family member (F)-C on April 21, 2016 at 3:12 p.m. revealed C1 spoke with F-E when F-E was at the facility cleaning out C2's apartment and learned of C2 ' s missing credit cards. C1 reported to her family that she too was missing a credit card. F-C checked C1's credit card statements and noticed charges on C1's credit card that C1 would not have made at nearby retailers. F-C spoke with C1 and other family members of C1 and no one used the credit card at those retailers. F-C contacted police and the comprehensive home care provider. Interview with the family member (F)-D on April 21, 2016 at 4:15 p.m. revealed he was contacted by police after NA-F admitted to taking C3 ' s credit card from the C3's clothing pocket while the NA-F was doing C3 ' s laundry. F-D did not notice any unauthorized charges on C3 ' s credit card. Interview with campus administrator (CA)-B on April 15, 2016 at 1:51 p.m. revealed she was contacted by F-E and informed that when F-E was cleaning out C2 ' s apartment she was unable to locate two credit cards belonging to C2. F-E discovered charges C2 did not make because C2 was at the hospital, subsequently on hospice care, and later deceased, so she notified police and facility staff. CA-B also said C1 spoke with the F-E when F-E was at the facility and learned of C2 ' s missing credit cards. CA-B said police brought her surveillance footage of the person who used the credit cards for C1 and C2 and she identified NA-F as the person in the surveillance footage.	0 325		

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0 325	Continued From page 4 A police report dated March 22, 2016 indicated F-E contacted police after discovering C2 was missing two credit cards and noticing some charges on one of the credit cards C2 could not have made. Police were also contacted by F-C after C1 had talked to the F-E and noticed C1 was missing a credit card and noticed some charges on the credit card C1 did not make. Police obtained surveillance footage from retailers were the credit cards were used and brought the footage to CA-B who identified NA-F to police. Police interviewed NA-F and she admitted to: taking and using C1 ' s credit card on the following dates December 1, 6, 7, and 9 2015 totaling $264,24, taking two credit cards from C2 and using one of them on February 9, 12, and 13 2016 totaling $166.21, and taking a credit card from C3. Police issued a citation to NA-F for taking the credit cards from all three clients and forwarded their investigation findings to the county attorney for formal charges for the unauthorized financial card transactions. A policy dated August 5, 2014 and titled "Vulnerable Adult Abuse Prevention Plan" reveals on page 2 "any form of resident abuse, neglect, or exploitation will not be tolerated." TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 325		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
H27949		10/4/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
STONECREST	8725 PROMENADE LANE WOODBURY, MN 55125

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 00325 Reg. # 144A.44, Subd. 1(14) LSC	Correction Completed 10/04/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 5/16/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			