MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: The Waters Senior Living Management LLC		**Report Number:** HL30281005	**Date of Visit:** January 18, 2017
Facility Address: 1600 Hopkins Crossroad		**Time of Visit:** 8:30 a.m. to 1:30 p.m.	**Date Concluded:** July 6, 2017
Facility City: Minnetonka		**Investigator's Name and Title:** Darin Hatch, Special Investigator Casey DeVries, RN, Special Investigator	
State: Minnesota	**ZIP:** 55305	**County:** Hennepin	

☒ **Home Care Provider/Assisted Living**

Allegation(s):
It is alleged that a client was financially exploited when the alleged perpetrator (AP) stole several pieces of jewelry, with a total value of approximately $6050, 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 is substantiated. The alleged perpetrator (AP) took two rings that belonged to the client and pawned them for cash.

The client received services from a provider licensed as a comprehensive home care provider. The client received medication management according to a service agreement and care plan.

Interviews with the client and the client's family revealed several pieces of jewelry were missing from the client's apartment. The client's family contacted police and described the missing jewelry. The client said during interview s/he noticed the jewelry missing shortly after receiving medication administration from the AP, and after the AP had used the client's restroom located in the bedroom.

Interviews with facility staff revealed the AP was the only staff observed on video surveillance tape in the client's room. When staff interviewed the AP, the AP said s/he was in the room to retrieve some supplies s/he left in the room.

During an interview, the AP admitted s/he pawned two rings. The AP asserted s/he found the rings outside of the building on the sidewalk, near an entrance, in a cloth pouch. The AP admitted those rings likely belonged to a client at the facility and that s/he should have turned them into the facility.

Contact with law enforcement revealed that pawn records showed the AP pawned a ring for cash, which

belonged to the client. Police forwarded the case to the city attorney for review.

The facility terminated the AP's employment.

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 home care provider had policies in place to address financial exploitation. 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.

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 Not Met
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:

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:

- ☒ Medical Records
- ☒ Care Guide
- ☒ Medication Administration Records
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Care Plan Records
- ☒ Facility Incident Reports
- ☒ ADL (Activities of Daily Living) Flow Sheets
- ☒ Service Plan

Other pertinent medical records:

- ☒ Police Report

Additional facility records:

☒ Staff Time Sheets, Schedules, etc.

☒ Facility Internal Investigation Reports

☒ Personnel Records/Background Check, etc.

☒ Facility In-service Records

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: 0

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 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: Eight

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Eight

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:

☒ Cleanliness

☒ Dignity/Privacy Issues

☒ Safety Issues

☒ Meals

☒ 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

Minneapolis Police Department

Hennepin County Attorney

Minneapolis 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
	H30281	A. BUILDING: _____ B. WING _____	C 03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS SR LVG MGMT LLC	1600 HOPKINS CROSSROAD MINNETONKA, MN 55305

(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(s) has 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 January 18, 2017, a complaint investigation was initiated to investigate complaint #HL30281005. At the time of the survey, there were 43 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 Minn. Stat. 144A.474 subd. 11 (b) (1) (2)	
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:	0 325		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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 the right of one of one client (C1) reviewed to be free from maltreatment (financial exploitation) when a staff member pawned jewelry that belonged to C1. The violation occurred as 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 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). The findings include: C1's file was reviewed. C1 received comprehensive home care services for medication management from the provider according to a service agreement and care plan dated June 22, 2016. Interview with C1 on January 18, 2017 at 11:48 a.m. revealed unlicensed professional (ULP)-E came into C1's room to administer eyedrops on July 30, 2016 and asked to use her bathroom. The following day C1 noticed she was missing several pieces of jewelry. C1 notified her family. Interview with family member (F)-A on January 17, 2017 at 11:32 a.m. revealed C1 notified her	0 325		

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0 325	Continued From page 2 on July 31, 2016, and said she was missing several pieces of jewelry. F-A said C1 suspected ULP-E because ULP-E had asked to use the bathroom on July 30, 2016 and used the bedroom bathroom instead of the main one off the living room. F-A called the police and notified the licensee. F-A gave a description of the jewelry to police, and told them she and C1 suspected ULP-E of taking the jewelry. Interview with director of community relations (DCR)-C on January 18, 2017 at 8:50 a.m. revealed he was notified of the suspected theft of jewelry by F-A on August 1, 2016 and began reviewing surveillance video of C1's room. ULP-E was the only staff person observed entering C1's room. DCR-C interviewed ULP-E and she said she was in C1's room because she forgot some supplies and went in to retrieve them. DCR-C said he terminated the employment of ULP-E. Interview with police on January 20, 2017 at 10:33 a.m. revealed police identified one ring that belonged to C1 that was pawned for cash by ULP-E. Police forwarded their findings to the city attorney for criminal charging. During an interview with ULP-E on February 22, 2017 at 5:07 p.m., ULP-E stated she found jewelry in a pouch outside the building on the ground near an entrance while she was smoking. ULP-E said there were two rings in the pouch and she pawned both of them for cash. ULP-E admitted she should have turned the rings in to the facility as they likely belonged to a client, but she needed the money and feels bad for what she did. ULP-E was unable to recall the date, time, or descriptions of the rings or the location of the pawn shop she pawned them at.	0 325		

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0 325	Continued From page 3 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 325		
0 805 SS=D	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to ensure that one of one incidents of suspected financial exploitation reviewed was reported to the Minnesota Adult Abuse Reporting Center (MAARC) as required. The violation occurred as 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 file was reviewed. C1 received comprehensive home care services from the provider according to a service agreement and care plan dated June 22, 2016. Interview with director of community relations (DCR)-C on January 18, 2017 at 8:50 a.m. revealed a family member of C1 reported on August 1, 2016 some jewelry was lost or stolen. DCR-C began investigating and reviewing	0 805		

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0 805	Continued From page 4 surveillance footage. DCR-C said he suspected a staff member on August 19, 2016 after he observed unlicensed professional (ULP)-E in C1's room on the surveillance video. DCR-C said he did not report the suspected financial exploitation to the Minnesota Adult Abuse Reporting Center (MAARC) until September 15, 2016. A policy dated September 28, 2015 and titled "Reporting of Maltreatment of Vulnerable Adults" indicates on page two and three staff members will report incidents of suspected maltreatment as required by Minnesota Statute. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 805		
02015 SS=D	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 5 (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 6 This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to ensure that one of one incidents of suspected financial exploitation reviewed was reported to the Minnesota Adult Abuse Reporting Center (MAARC) as required. The violation occurred as 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 file was reviewed. C1 received comprehensive home care services from the provider according to a service agreement and care plan dated June 22, 2016. Interview with director of community relations (DCR)-C on January 18, 2017 at 8:50 a.m. revealed a family member of C1 reported on August 1, 2016 some jewelry was lost or stolen. DCR-C began investigating and reviewing surveillance footage. DCR-C said he suspected a staff member on August 19, 2016 after he observed unlicensed professional (ULP)-E in C1's room on the surveillance video. DCR-C said he did not reported the suspected financial exploitation to the Minnesota Adult Abuse Reporting Center (MAARC) until September 15, 2016. A policy dated September 28, 2015 and titled "Reporting of Maltreatment of Vulnerable Adults"	02015		

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02015	Continued From page 7 indicates on page two and three staff members will report incidents of suspected maltreatment as required by Minnesota Statute. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02015		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 18, 2017

Ms. Pamela Pklingfas, Administrator
The Waters Sr Living Management LLC
1600 Hopkins Crossroad
Minnetonka, MN 55305

RE: Complaint Number HL30281005

Dear Ms. Pklingfas :

On August 16, 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 March 16, 2017 with orders received by you on July 14, 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

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