Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL31872001M
Compliance #: HL31872002C

Date Concluded: March 2, 2020

Name, Address, and County of Licensee Investigated:
Freedom Home Care LLC
101 North 2nd Street
Mankato, MN 56001
Le Sueur County

Facility Type: Home Care Provider

Investigator's Name:
Lisa Coil, RN, BSN, Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):
It is alleged: The Alleged Perpetrator (AP) financially exploited the client when she removed medications from the client's home.

Investigative Findings and Conclusion:
Financial exploitation was substantiated. The AP was responsible for the maltreatment. The client's prescribed medications were missing following the AP being at the client's home.

The investigation included interviews with facility administrative staff and the client's family. The client's medical records and facility policies and procedures were reviewed. In addition, the law enforcement report was reviewed.

During an interview, the client's family member indicated a bag of medications had been picked up from the pharmacy and placed on the client's kitchen table. The AP had been in the house with the client while the family member was outside doing yard work. When the family member returned to the house, she stated she noticed the bag of medication missing from the kitchen

table. The family member placed a call to the AP, and the AP offered to come back and help find the medication, which the family member declined. Later that evening when the family member went to take some medication, she discovered more narcotic medication missing from a kitchen drawer. The family member indicated the AP was the only person in the home the day the medications went missing. The family member placed a phone call to the facility and law enforcement the next morning.

During an interview, facility management indicated they had received a phone call from the family member the next morning regarding missing medication believed to have been taken by the AP. The family member also notified the facility that law enforcement had already been contacted. The facility indicated medication management was not part of the client's service agreement. The AP was immediately suspended AP during investigation.

Review of the police report revealed the AP admitted to taking the narcotic medications from the client's home. During a police search of the client's home, hydrocodone/acetaminophen tablets, fentanyl patches, and tramadol tablets were discovered; all of these medications were reported to be missing by the client's family member.

A subpoena was sent to AP for an interview with no response.

In conclusion, financial exploitation by drug diversion was substantiated. The AP admitted to diverting the client's narcotic medications.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:
(1) Engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or
(2) Fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.
(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;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) Forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: Yes.

Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No. The AP did not respond to subpoena.

Action taken by facility:
The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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.

cc:
The Office of Ombudsman for Long-Term Care
County Attorney for county where incident occurred
City Attorney for city where incident occurred
Le Sueur County Sheriff's Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H31872	A. BUILDING: _____ B. WING _____	C 02/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREEDOM HOME CARE LLC	101 N 2ND STREET SUITE 100 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 ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On February 4, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL31872002C/#HL31872001M. At the time of the survey, there were 30 clients receiving services under the comprehensive license. The following correction orders are issued for HL31872002C, tag identification 0805 and 2015. A maltreatment determination is also issued for HL31872001M, tag identification 0325.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. 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 number out of compliance are 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 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/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: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms	0 325		

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0 325	Continued From page 1 of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure one of one client (C1) reviewed was free from maltreatment. C1 was financially exploited. Findings include: On March 2, 2020, the Minnesota Department of Health (MDH) issued a determination that financial exploitation occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No Plan of Correction (PoC) is required. Refer to the public maltreatment report for details.	
0 805 SS=D	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors Subd. 6. Reporting maltreatment of vulnerable adults and minors. (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care provider must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.	0 805		

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0 805	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview, and record review, the facility failed to immediately report to the state agency (SA) financial exploitation for one of one client (C2) reviewed for maltreatment. The owner/administrator (ADM)-A indicated he investigated an incident regarding suspicious charges on C2's credit card. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: When interviewed on February 4, 2020 at 2:22 p.m., ADM-A indicated he had received notification a couple of weeks ago regarding suspicious purchases made with C2's credit card. He further indicated he continued to work with the family to get to the bottom of the charges, and did not report this incident to the SA. Review of the Minnesota Adult Abuse Reporting Center (MAARC) report filed after the special investigator recommendation on February 7, 2020, indicated ADM-A received a call from on January 8, 2020, relaying information that a client's credit card may have been misused by another employee of the facility. A policy titled, Maltreatment of Vulnerable Adults Mandated Reporting, undated, indicated	0 805		

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0 805	Continued From page 3 suspicion that a vulnerable adult has been maltreated must be reported immediately. The policy further indicated the Managing Member (in this case ADM) is responsible for deciding if an internal report must be forwarded to the common entry point and must be forwarded within 24 hours. 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 (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	02015		

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02015	Continued From page 4 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. This MN Requirement is not met as evidenced by: Based on interview, and record review, the facility failed to immediately report to the state agency (SA) financial exploitation for one of one client (C2) reviewed for maltreatment. The owner/administrator (ADM)-A indicated he investigated an incident regarding suspicious	02015		

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02015	Continued From page 5 charges on C2's credit card. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: When interviewed on February 4, 2020 at 2:22 p.m., ADM-A indicated he had received notification a couple of weeks ago regarding suspicious purchases made with C2's credit card. He further indicated he continued to work with the family to get to the bottom of the charges, and did not report this incident to the SA. Review of the Minnesota Adult Abuse Reporting Center (MAARC) report filed after the special investigator recommendation on February 7, 2020, indicated ADM-A received a call from on January 8, 2020, relaying information that a client's credit card may have been misused by another employee of the facility. A policy titled, Maltreatment of Vulnerable Adults Mandated Reporting, undated, indicated suspicion that a vulnerable adult has been maltreated must be reported immediately. The policy further indicated the Managing Member (in this case ADM) is responsible for deciding if an internal report must be forwarded to the common entry point and must be forwarded within 24 hours. TIME PERIOD FOR CORRECTION: Twenty-one	02015		

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