Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: H5083099M

Date Concluded: September 30, 2021

Name, Address, and County of Licensee Investigated:
Park Health a Villa Center
4415 West 36 – ½ street
St Louis Park, MN 55416-4854
Hennepin County

Facility Type: Nursing Home

Investigator's Name: Carol Moroney, RN, 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 facility financially exploited residents when the facility overcharged for care they received.

Investigative Findings and Conclusion:
Financial exploitation was substantiated. The alleged perpetrator (AP), facility staff, was responsible for the maltreatment. The resident's family had concerns regarding charges in the resident's bank account. The facility investigated and determined funds had been misapplied in the resident's bank account. The facility completed an audit of all of the resident's trust (bank) accounts and discovered the AP had stolen approximately $37,000.00 from 15 different residents.

The investigation included interviews with facility staff members, including administrative and nursing staff. In addition, the investigator contacted law enforcement and reviewed the investigation completed by the AP's bank regarding deposits and transactions. The investigation included reviewed of facility policy and procedures, resident medical records, and employee files.

The facility completed a financial audit on all client's trust fund accounts from January 2020, until June 2020. The facility discovered 15 residents were missing money from their bank account. The AP, who was also the business office manager, deposited resident checks into her own personal bank account. The resident checks were written out "pay to the order of" using the AP's name. The AP would deposit the residents checks into her personal account without the resident's knowledge, and then change the facility computer tracking system so "pay to the order of" indicated the check was written out to a business or a bill the resident had to pay. It was determined the AP deposited checks into her personal account from 15 different residents totaling approximately $37,000.00.

The AP deposited checks into her personal account for the following residents:
Resident #2- $16.87;
Resident #3- $64.46;
Resident #4- 283.00;
Resident #5- $155.00;
Resident #6- $8000.00;
Resident #7- $12,016.19;
Resident #8- $2,249.01;
Resident #9- $411.00;
Resident #10- $6,637.64;
Resident #11- $3663.05;
Resident #12- $841.31;
Resident #13- $30.02;
Resident #14- $15.00;
Resident #15- $1095,00; and
Resident #16- $1215.65.

The AP's financial institution investigation indicated after review of records and video tapes; they concluded the AP made fraudulent deposits into her personal financial institution account. The financial institution completed an investigation and found the AP made 38 deposits to her own bank account totaling approximately $37,000.00. The financial institution also supplied security cameras footage to law enforcement, of the AP withdrawing money frequently from her own account at ATMs in convenient stores and in a casino. The financial institution provided their investigation results to law enforcement.

According to the law enforcement investigation conclusion, the AP would, because of her position, alter the resident's checks for her own purposes. The AP changed the client's check of

“pay to the order” to herself, cash the check, and changed the “pay to the order of” back to the original payee. The report mentioned 15 victims missing approximately $37,000.00 from their accounts.

In conclusion, financial exploitation was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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;

Vulnerable Adult interviewed: No, unable to be interviewed.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, a subpoena was sent with no response.

Action taken by facility:
The facility completed an audit of all resident’s trust accounts. Reported theft to law enforcement and the AP was 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
Hennepin County Attorney
Saint Louis Park City Attorney
Saint Louis Park Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00129	A. BUILDING: _____ B. WING _____	C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH A VILLA CENTER	4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H5083099M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	2 000		

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2 000	Continued From page 1 #H5083099M, tag identification 1850. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.	21850		

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21850	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure 15 of 16 residents reviewed (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15 and R16) was free from maltreatment. R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15 and R16 was financially exploited. Findings include: On September 30, 2021, 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.	21850		