DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: H5628043M **Date Concluded:** October 6, 2021

Name, Address, and County of Licensee Investigated:
Minnesota Veterans Home
56 Outer Drive
Silver Bay, MN 55614
Lake County

Facility Type: Nursing Home **Investigator's Name:** Jeri Gilb, RN, MSN, CNP
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 three facility staff members, alleged perpetrator (AP)1, AP2, and AP3, financially exploited the resident when they accepted money from the resident.

Investigative Findings and Conclusion:
Financial exploitation was substantiated. AP1 and AP2 were responsible for the maltreatment. AP1 and AP2 cashed checks from the resident for their own personal use.

The investigation included interviews with facility staff members, including unlicensed staff. In addition, the investigator reviewed facility policies, the residents medical records, staff training records, and facility investigation reports. The investigator contacted law enforcement and obtained the police report.

The resident had diagnoses including post-traumatic stress disorder, major depressive disorder, and chronic obstructive pulmonary disease. The resident required assistance with medication management, bathing and grooming assistance, mobility assistance, and meal service. The resident was oriented and had full control of his finances.

The facility investigation indicated the resident reported he gave money to AP1, AP2, and AP3. AP1 cashed seven different checks from the resident which totaled $8300. Several of the checks had personal memo notes such as “New boots!”, “Ho, ho, ho”, and “you are special”.
AP2 cased one check from the resident totaling $1000.
AP3 also cashed one check from the resident totaling $200.

When interviewed, AP1 stated she cashed checks for the resident but gave the cash to the resident after cashing the checks. AP1 was aware staff should not accept money or gifts from residents.

When interviewed, AP2 stated she accepted and cashed the $1000 the resident gave her. AP2 was aware staff should not accept money or gifts from residents.

When interviewed, AP3 stated he cashed a check from the resident but returned a check to the resident after he realized it was against policy. AP3 stated the resident had given him a check as a gift for a recent special occasion.

Review of facility training records indicated all three APs received and signed vulnerable adult training and boundaries training.

Review of law enforcement records indicated the resident reported giving money to AP1, AP2, and AP3. The resident stated AP did not cash the checks and give any money back to him.

In conclusion, financial exploitation was substantiated. AP 1 and AP 2 took money from the resident for their own personal use.

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;

(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: No, client declined interview
Family/Responsible Party interviewed: No, client is his own responsible party
Alleged Perpetrators interviewed: Yes

Action taken by facility: Investigated the allegation and the alleged perpetrators are no longer employed at the facility.

Action taken by the Minnesota Department of Health:

The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment. 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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING: ______ B. WING ______	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	**56 OUTER DRIVE** **SILVER BAY, MN 55614**

(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 #H5628043M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders are issued for #H5628043M, tag identification #1850.	2 000		

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

Minnesota Department of Health

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