*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL20166001M
**Compliance #:** HL20166002C

**Date Concluded:** May 11, 2022

**Name, Address, and County of Licensee Investigated:**
Central Minnesota Senior Care
2323 Gorton Avenue Southwest
Willmar, Minnesota 56201
Kandiyohi County

**Facility Type: Assisted Living Facility (ALF)**

**Evaluator'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: The resident was financially exploitation when the alleged perpetrator (AP) accepted cash from the resident for their own personal use. In addition, it is alleged the resident purchased illegal substances from facility staff.

**Investigative Findings and Conclusion:**
Financial exploitation was substantiated. Based on a preponderance of evidence, the AP is responsible for the maltreatment. The AP accepted money from the resident for her own personal use. There was no evidence the resident purchased illegal substances from facility staff.

The investigation included interviews with facility staff members, adult protection, and the resident. In addition, the investigator reviewed the resident's medical records, facility policies and procedures, incident reports, employment and training records, and law enforcement reports.

The resident's medical record indicated diagnoses of intracerebral hemorrhage with left side hemiplegia. He managed his own finances.

During an interview, Adult Protection Specialist (APS)-C stated the resident had a long history of financial exploitation by friends, family, and strangers. APS-C stated she investigated an incident of the resident's family member completing large sums of cash withdrawals from the resident's account. The family member stated the resident made withdrawals to purchase marijuana from facility staff. The family member was unable to provide names, dates, or details of any incidents of the resident buying marijuana from describe the staff. The APS-C stated the county attorney charged the family member with theft from the resident.

During an interview, program coordinator (PC)-B stated she overheard the resident ask the AP how much money she needed to buy her child a bike. PC-B questioned the resident about the incident. The resident stated he had given the AP money before, but it was his money, and he could do what he wanted with it.

During an interview, the alleged perpetrator (AP) denied receiving any money or gifts from the resident.

During an interview, the resident stated he gave the AP $300-$400 when she worked at the facility, but it is his money, and he can do as he likes with his money. The resident denied buying marijuana from staff or smoking marijuana at the facility.

Review of the facility's internal investigation indicated the resident admitted giving the AP a couple hundred dollars. The AP initially denied receiving any money from the resident, but then admitted to the facility she received $150 from the resident. The AP is no longer employed at the facility.

In conclusion, financial exploitation is 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;
(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**: No, vulnerable adult is own guardian
**Alleged Perpetrator interviewed**: Yes
**Action taken by facility:** Internal investigation, alleged perpetrator is no longer employed at 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
The Office of Ombudsman for Mental Health and Developmental Disabilities
Kandiyohi County Attorney
Willmar City Attorney

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 20166 | A. BUILDING: _____ B. WING _____ | C 03/15/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CENTRAL MINNESOTA SENIOR CARE | 2323 GORTON AVENUE SW WILLMAR, MN 56201 |

| (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 |
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| 0 000 | Initial Comments<br><br>Initial comments<br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.10 to 144G.93, the Minnesota Department of Health issued correction orders pursuant to an investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>On March 15, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL20166001M/HL20166002C. At the time of the investigation, there were #13 clients receiving services under the assisted living license.<br><br>The following correction orders are issued for #HL20166001M/HL20166002C, tag identification 0630 and 2360. | 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 for Assisted Living Facilities. 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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.<br><br>Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction."<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3. | |
| 0 630 SS=G | 144G.42 Subd. 6 Compliance with requirements for reporting ma | 0 630 | | |

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| 0 630 | Continued From page 1<br><br>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop and implement an individual abuse prevention plan (IAPP) for one of one resident, R1, reviewed for financial exploitation. The resident had a history of being financially exploitated by staff, family,and strangers. The facility did not ensure R1's IAPP included specific measures to be put into place to minimize the risk of financial exploitation.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>Findings include:<br><br>The resident's service plan dated October 28, 2021, indicated diagnoses of intracerebral hemorrhage with left side weakness, chronic | 0 630 | | |

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| 0 630 | Continued From page 2<br><br>obstructive pulmonary disease, and major depressive disorder. The resident required assistance with meal preparation, medication management, assistance with bathing, dressing, hygiene, and stand-by assistance with transfers and mobility..<br><br>During an interview, on March 15, 2022 at 11:05 a.m., Adult Protection Specialist (APS)-C stated the resident had a history of financial exploitation by friends and family. A family member was recently charged with theft after he stole money from the resident.<br><br>Court documents dated March 3, 2022 indicated the resident's family member was charged with two counts of theft from May 9, 2021 through November 4, 2021. Count I is a felony charge and Count II is a gross misdemeanor charge.<br><br>A facility internal investigation dated March 3, 2021 indicated from 2016, until 2019, the resident sent an estimated $400,000 to a friend who was a prisoner in the Oklahoma Prison System. This occurred over a 3-4 year timeframe. The resident manages his own finances. The investigation noted MAARC reports were filed 9/16/2020 and 3/3/2021 for this incident.<br><br>A facility internal investigation dated 12/22/2021, indicated the resident admitted giving unlicensed personal (ULP)-A a "couple hundred dollars." ULP-A initially denied receiving any money from the resident, but then admitted she received $150 from the resident two months prior. The internal investigation resulted in termination of ULP-A for violation of Staff Funds and Property Procedures of the Individuals We Serve Policy and MN Statute 144A.479 Subd. 5(a). | 0 630 | | |

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| 0 630 | Continued From page 3<br><br>During an interview on March 29, 2022 at 2:22 p.m., ULP-A denied receiving money or gifts from R1. She stated he is old with dementia and she is unsure why he would say he gave her money. She stated she received training from the facility and knows not to take any money or gifts from residents.<br><br>During an interview on May 6, 2022 at 3:11 p.m., the resident stated he gave ULP-A about $300-$400, but it is his money and he will do what he likes with that money.<br><br>The resident's Individual Abuse Prevention Plans (IAPP) dated August 23, 2019 and March 31, 2022, indicated the resident is not susceptible to financial abuse by other individuals. The facility neglected to develop and implement any interventions for financial exploitation of the resident, despite the knowledge of the resident's vulnerabilities to financial exploitation since 2016.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 630 | | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was financially exploited. | 02360 | No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag. | |

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| 02360 | Continued From page 4<br>Findings include:<br><br>On March 15, 2022, 2022, the Minnesota Department of Health (MDH) issued a determination that financial exploitation occurred, and 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. | 02360 | | |