Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202019886M
Compliance #: HL202017915C

Date Concluded: February 7, 2024

Name, Address, and County of Licensee Investigated:
Lakewood Manor
222 5th Street NE
Staples, MN 56479
Todd County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Investigation:
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.

Initial Investigation Allegation(s):
The alleged perpetrator (AP), a facility staff member, financially exploited the resident over a period of eight months, when the AP collected the resident's rent payment in cash each month but did not deposit the money or apply the money to the resident's account.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The alleged perpetrator (AP)/facility staff member was responsible for the maltreatment. The AP was responsible for facility billing procedures. The resident made a total of $6,400 in cash payments directly to the AP for rent but the payments were not documented as received and were not applied toward the resident's account.

The investigator conducted interviews with facility management. The investigator also contacted law enforcement. The investigation included review of the resident's records including billing statements and the facility's internal investigation.

The resident resided in an assisted living facility. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident was independent with most activities of daily living and was cognitively intact.

The facility's internal investigation indicated the AP was terminated for reasons unrelated to billing procedures. After the AP was terminated, additional facility staff were trained on how to run financial reports and complete facility billing procedures. During the training, a discrepancy was noted with the resident's account, and it appeared he had not paid rent for eight months. Facility staff interviewed the resident. The resident reported the accurate amount of rent due ($793) but stated he paid $800 each month in cash to the AP when she came to his apartment each month to collect the rent money. The resident stated he requested a receipt but was only occasionally provided with one. The resident provided facility staff with four receipts which matched the facility's ledger book kept in the AP's office. The signature of the staff person who received the money was scribbled and not legible. Three receipts showed $800 cash was received and the fourth showed $750 cash was received. The receipts had the resident's name spelled incorrectly. The resident told facility staff he did not notice it showed $750 but confirmed he paid the AP $800 each time and was never given any change back. The internal investigation indicated the accounts receivable department was not able to locate any record of cash deposits or cash being sent to the office to be deposited over an eight-month lookback period.

Facility billing records indicated the resident had an outstanding rent balance due that would have would have displayed on aging reports and bad debt reports. Facility records included two credit adjustment forms completed by the AP that requested for four months of the resident's private pay amount to be zeroed out, as it was "billed in error, private pay amount owed should be zero." Once the accounts were zeroed out, they were removed from the outstanding balance reports. Facility ledgers, provided for the eight-month lookback period, included records of resident rent payments made by other residents who paid with checks, towards rent received by the AP. The spreadsheets contained no evidence of cash payment records from the resident and no other resident payments or checks were missing from this time frame.

During an interview, the facility's vice president (VP) stated after the AP was terminated, the VP and another employee were learning how to complete billing and financial statements for the assisted living facility, and something didn't look right with the resident's account. The VP stated after they spoke with the resident and investigated the issue more, they were not able to account for the monthly rent payments made by the resident to the AP. The VP stated any cash deposits should have been sent to a central business office to make the bank deposit, but no cash deposits were received. The VP stated they kept records of all checks and payments sent to the facility cashier on a ledger form and no other payments were missing or unaccounted for. The VP stated eight months of ledger forms with deposits were reviewed and none of them contained the resident's cash payments. The VP stated checks and payment were brought to the facility cashier personally by the AP or another administrative staff member. The VP stated

the AP completed the resident's assisted living contract and the resident's name was misspelled on the contract, identical to how it was misspelled on the payment receipts. The VP stated the AP was trusted to manage the assisted living billing and was responsible for bringing forward any bad debt concerns at the facility's regular past due/bad debt meeting. Over the course of several months, the AP never mentioned the resident not paying rent or that cash payments were not applied to his monthly statement.

During an interview, an administrative employee stated the AP ran the monthly statements and completed billing on her own, and often completed this task from her home. The administrative employee stated she helped stuff envelopes and mailed or delivered statements but that was the extent of her involvement with the billing process. The administrative employee stated either she or the AP brought deposits to the nursing home business office for deposit and the practice was to physically bring them to the office. The administrative employee stated a courier was used to send things over to the nursing home, but she was not sure why cash would have been sent via courier.

During an interview, the resident stated he recently moved into the facility and preferred to pay his rent in cash. The resident said he never received a monthly billing statement reflecting what was due or that previous payments were applied but " always assumed it was paid because I paid it." The resident stated, "It didn't seem normal, I'd ask to get a receipt and she'd [the AP] say oh, I'll get you one, and then I wouldn't see her again until it was time to collect again." The resident stated the only person he paid in cash was the AP. The resident said he never got change back or received credit for the overpayment and only periodically received a receipt for his payment.

During an interview, the AP denied financially exploiting the resident and stated "No, absolutely not, I've been working in this field for over a decade. I've never stolen resident funds or diverted them. Absolutely not, I'd have no reason to." The AP confirmed the resident paid his rent in cash and usually paid her directly but sometimes he would give it to other staff members, and they would send the cash over to the nursing home to be deposited and she wouldn't see it. The AP stated any time she took a cash payment she provided a receipt. The AP indicated her signature was normally legible, but agreed the receipts in the resident's possession would have likely come from her. The AP confirmed the resident overpaid rent each month and instead of giving change back, it was applied as a credit toward his billing statement. The AP stated the cash payment was placed in a manila inter-departmental routing envelope and sent to the nursing home via courier with a ledger attached. When asked why the facility had no records of the ledger or any cash payments she received, the AP stated she didn't know, but that multiple people had access to the money and ledger. The AP was not sure why billing statements did not reflect overpayments or credits. The AP stated she never completed billing alone; it was always done in conjunction with another administrative staff member and when cash was sent via courier, multiple people had access to the cash, so she wasn't sure what would have happened to it. The AP didn't recall the resident's diagnoses, but indicated he was cognitively intact and agreed he would be a reliable reporter.

In conclusion, the Minnesota Department of Health determined 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;
(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: Attempted
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility immediately contacted law enforcement and made a MAARC report upon discovery of the issue. The facility audited all resident financial records to identify any additional discrepancies. The AP was terminated for unrelated reasons when the issue was identified and the resident was not required to pay back the $6,400.

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.

You may also call 651-201-4200 to receive a copy via mail or email.

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
Todd County Attorney
Staples City Attorney
Staples Police Department
Minnesota Board of Executives for Long Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20201	A. BUILDING: _____ B. WING _____	C 12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD MANOR	222 5TH STREET NE STAPLES, MN 56479

(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****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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: #HL202019886M/#HL202017915C On December 14, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 22 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL202019886M/#HL202017915C, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License 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 144G.31 subd. 1, 2, and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02360	Continued From page 1 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	