DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL20549002M **Date Concluded:** July 28, 2022
Compliance #: HL20549003C

Name, Address, and County of Licensee Investigated:
Callista Court
1455 West Broadway
Winona, MN 55987
Winona County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Shannan Stoltz, 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.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) financially exploited three residents (Resident 1, Resident 2, Resident 3) when the AP took items from their apartments without their permission.

Investigative Findings and Conclusion:
The Minnesota Department of Health (MDH) determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP admitted to the theft and criminal charges were filed.

The MDH investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed law enforcement and family members of the residents. The investigation included an onsite visit for observations, review of medical records, and review of facility policies and procedures. The investigation further included review of surveillance videos and police reports.

Resident 1 resided in an assisted living facility with a diagnosis of osteoarthritis. The resident's service plan indicated she was mostly independent and cognitively intact with occasional forgetfulness.

Resident 2 resided in an assisted living facility with a diagnosis of high blood pressure. The resident's service plan included medication administration and indicated he was cognitively intact with occasional forgetfulness.

Resident 3 resided in an assisted living facility with a diagnosis of high blood pressure. The resident's service plan indicated she was mostly independent and cognitively intact with occasional forgetfulness.

During interviews, administrative staff stated they watched facility surveillance camera footage following Resident 1's report of missing items from her apartment. The administrators stated they observed the AP enter Resident 1's room with an empty cart and exit with the cart full of several bags. The AP then pushed the cart out the door and transferred the bags into her personal vehicle. The administrators indicated they watched several hours of surveillance tape and discovered the AP had also taken items from Resident 2. The administrators filed a police report and began an internal investigation, during which they discovered the AP had also stolen items from Resident 3.

Review of the police report indicated the AP admitted to the thefts and some of the missing items were recovered from the AP's residence. The report identified criminal charges were filed against the AP.

During an interview, Resident 1 stated she returned to her apartment after a weekend away, discovered items were missing and reported this to facility administration. The resident stated she is very happy living at the facility and the facility reimbursed her for the stolen items.

During an interview, Resident 2 stated the items stolen were not of great monetary value, but were of sentimental value, as his late wife was the person who had purchased the items. The resident stated he is very happy living at the facility and the facility is in the process of reimbursing him.

Resident 3 was unavailable for interview.

During interviews with family members of the residents they confirmed that the facility had reimbursed or were in the process of reimbursing the residents.

Attempts to contact the AP were unsuccessful.

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:
(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 -resident's 1 and 2; resident #3 - deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No; did not present for scheduled interview.

Action taken by facility:
The facility contacted law enforcement and conducted an immediate internal investigation. The AP's access to the facility was immediately denied and the AP is no longer employed by the facility. Re-education was provided to facility staff regarding financial exploitation.

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.

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
Minnesota Nurse Aide Registry
Minnesota Department of Human Services Background Studies
Winona County Attorney
Winona City Attorney
Winona Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20549	A. BUILDING: ______ B. WING ______	C **07/12/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALLISTA COURT	**1455 WEST BROADWAY STREET WINONA, MN 55987**

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: HL20549002M/HL20549003C On July 12, 2022, the Minnesota Department of Health conducted a complaint investigation at the above facility, and the following correction order is issued. At the time of the complaint investigation, there were 91 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL20549002M/HL20549003C, tag identification 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. 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." 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

Minnesota Department of Health

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the licensee failed to ensure three of 91 residents reviewed (R1, R2, R3) were free from maltreatment. R1, R2, and R3 were financially exploited. Findings include: On July 12, 2022, 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.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	