Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL214105621M
Compliance #: HL214107864C

Date Concluded: December 30, 2024

Name, Address, and County of Licensee Investigated:
Sunrise of Roseville
2555 Snelling Avenue North
Roseville, MN 55113
Ramsey County

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

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Not Substantiated

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 perpetrators (AP1, AP2, AP3) financially exploited the resident when they stole money out of her wallet.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was not substantiated. AP1, AP2, and AP3 were observed on video going through the resident's wallet. However, AP1, AP2, and AP3 did not take anything from the resident's wallet and the resident did not incur a financial loss.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and family members. The investigation included review of the resident's record, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report,

and related facility policy and procedures. Also, the investigator observed staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included spinal stenosis and chronic obstructive pulmonary disease. The resident's services included assistance with activities of daily living, meals, and medication management. The resident's assessment indicated she received assistance with finances from her family.

The resident's progress notes indicated the facility observed on a recorded video AP1, AP2, and AP3 going through the resident wallet in her room.

A police report indicated AP1 was captured on camera looking through the resident's wallet. The resident's wallet was empty, so nothing was taken. AP 1 admitted looking through the resident's wallet but denied ever stealing cash from the resident.

A second police report indicated AP2 and AP3 had been fired from their positions for attempting to steal money from the resident. A facility manager stated the resident's family member provided video footage of both AP2 and AP3 separately entering the resident's apartment and searching through her wallet. The police report indicated it seemed AP2 and AP3 had deliberately entered the resident's apartment with the intent to go through the resident's wallet for money or other valuable items.

The recorded video footage indicated a camera was placed inside an open drawer of the resident's room. A staff member (identified by facility leadership and AP1) took the residents wallet out the drawer and rifled through it. AP1 returned the wallet to the drawer and closed the drawer without taking anything from the resident's wallet. AP1's face was clearly visible as she closed the drawer. On a different day, a staff member (identified as AP2 by the name tag) quickly opened the drawer. AP2 took out the resident's wallet and rifled through it. The video then ended. On the same day, another staff member (identified as AP3 by the name tag) opened the resident's drawer and started to go through it without removing it from the drawer. AP3 found nothing in the resident's wallet and closed the drawer.

The facility's internal investigation indicated AP2 and AP3 were counselled regarding alleged "abuse of resident/financial exploitation." AP2 did not provide a statement. AP3 said the resident asked her to help her find her keys. AP3 said the resident told her the keys might be in her wallet. AP3 searched the wallet and did not find the keys. A statement provided by the resident indicated the resident did not ask anyone to enter her room, she always had what she needed with her, and she did not want anyone in in her apartment if she was not there. AP1 did not provide a statement as she never returned to the facility.

Personnel files for AP1, AP2, and AP3 indicated all three staff members received training in abuse and neglect prevention, and compliance and code of conduct.

When interviewed, a facility administrator said the resident's family member informed her they were putting cameras in the resident's apartment because she was missing money. The family later provided video of AP1, AP2, and AP3 each looking through the resident's wallet on two separate days. The three staff members were put on paid administrative leave pending investigation. AP1 quit and never returned to the facility. Although the wallet was empty and no money was taken, AP2 and AP3 were each counselled and their employment was terminated.

When interviewed, AP2 said another resident lost his wallet and asked AP2 to help him find it. When AP2 entered the resident's apartment to clean, she looked in an open drawer and saw a wallet. AP2 said she looked through the wallet to see if it belonged to the other resident. AP2 denied stealing or trying to steal anything from the resident or any other resident at the facility.

When interviewed, AP3 said the resident asked her to help find the residents missing keys. AP3 said she looked through the resident's wallet to see if her keys were in it. AP3 denied stealing from the resident.

When interviewed, the resident said at one time she had $400 in a drawer, however, later that day she noticed she only had $200 left. The resident said she also won $500 at a casino, and a family member gave her $200 of it to keep. The resident could not remember when she noticed the money was missing, but the $200 was gone. The resident did not recall time frames when her money went missing but said a family member placed cameras in her room afterward.

When interviewed, a family member stated they placed cameras in the resident's apartment because she believed she was missing money, approximately $350. The family member said it was hard to pinpoint dates money went missing because there could have been a span of time between when the resident noticed money was missing and when it might have been taken. The family member also said they weren't sure if the resident misplaced the money or lost it. At one time, the family member gave the resident $200, which eventually went missing. After that, the family member placed the cameras in the resident's apartment.

In conclusion, the Minnesota Department of Health determined financial exploitation was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

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.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes, AP2 and AP3. AP1 did not respond to requests for interview.

Action taken by facility:
The facility retrained staff regarding resident rights and boundaries. The three staff members involved no longer work at the facility.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21410	A. BUILDING: _____ B. WING _____	C 11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF ROSEVILLE	2555 SNELLING AVENUE NORTH ROSEVILLE, MN 55113

(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 On November 19, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL214107864C/#HL214105621M. No correction orders are issued.	0 000		