Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL219635901M
Compliance #: HL219638440C

Date Concluded: November 12, 2024

Name, Address, and County of Licensee Investigated:
Silvercrest Properties LLC
8501 Flying Cloud Drive
Eden Prairie, MN 55344
Hennepin County

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

Evaluator's Name: Lena Gangestad, 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 financially exploited the resident when he took the resident's debit card and used it to purchase a $500.00 gift card at Walmart.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The alleged perpetrator was responsible for the maltreatment. The alleged perpetrator entered the resident's room, took the resident's debit card and then used it to purchase a $500.00 gift card at Walmart. The total transaction amounted to $505.94, which included the gift card fee.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of resident's records, the alleged perpetrator's personnel record, incident reports, and police report. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include Parkinson's disease and dementia. The resident's service plan included medication management and assistance of one person with dressing and toileting

One day, the family member who managed the resident's finances did not recognize a $504.94 charge on the resident's debit card statement. Upon checking, the resident was still in physical possession of the compromised debit card and had never apparently lost it. The resident denied making the transaction, so the family member reported it to the management of the facility, and the police were notified.

The police report indicated the alleged perpetrator used the resident's debit card to purchase a $500 gift card with an additional $5.94 fee. The same document indicated Walmart sent a photo of the individual and a copy of the receipt to the police department. The individual was identified as the alleged perpetrator, an employee of the facility. The police report provided the following timeline:

- The alleged perpetrator used his key fob to enter the resident's room at 10:04 AM.
- The alleged perpetrator left the facility at 10:11 AM.
- The alleged perpetrator was observed walking in the parking lot under surveillance at 10:12 AM.
- The alleged perpetrator's car was captured entering the Walmart parking lot at 10:22 AM.
- The alleged perpetrator returned to the facility at 10:40 AM.
- The alleged perpetrator's key fob accessed the resident's room again at 12:29 PM.

The police report also indicated the alleged perpetrator admitted to making the purchase with the resident's debit card. The alleged perpetrator told the police officer, 'The card was just sitting out on the table by the computer.' He took the card and purchased a gift card at Walmart so he could use it to pay bills. When he was done with the card, he put it back.

During an interview, the family member stated he was responsible for the resident's finances and noticed a charge he did not recognize. He then confirmed with the resident, who said he had not used the card. The family member informed the facility, which initiated an investigation and also contacted the police.

During an interview, a manager stated the family reported the situation to her, and she advised him to report it to the police. The manager stated the police contacted Walmart, which sent the facility a picture of the identified individual, and she recognized alleged perpetrator as one of her employees. She said the alleged perpetrator did not clock out when he left the facility, although facility surveillance showed him leaving the parking lot and returning 30 minutes later. Additionally, the manager stated the alleged perpetrator's key fob record showed he entered the resident's room and returned an hour later. She received the police report and terminated the alleged perpetrator's employment the following day.

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
(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, attempted but was not successful.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, attempts to interview were unsuccessful

Action taken by facility: Conducted an investigation, contacted the police, and ended the alleged perpetrator's employment.

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
Hennepin County Attorney
Eden Prairie City Attorney
Eden Prairie Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21963	A. BUILDING: _____ B. WING _____	C 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	8501 FLYING CLOUD DRIVE EDEN PRAIRIE, MN 55344

(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 October 23, 2024, the Minnesota Department of Health initiated an investigation of complaint HL219635901M/HL219638440C. The following correction order is issued, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment 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. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual alleged perpetrator 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.	