Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL281264383M
Compliance #: HL281267375C

Date Concluded: February 6, 2024

Name, Address, and County of Licensee Investigated:
New Challenges Inc., Afton
6880 St. Croix Trail S.
Hastings, MN 55033
Washington County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Lisa Coil, 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 multiple residents when the alleged perpetrator did not turn in receipts for cash rent and other receipts per licensee policy.

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 did not turn in resident #1's cash for rent. Additionally, the alleged perpetrator did not submit receipts for petty cash transactions and purchases for four other residents (residents #2, #3, #4, and #5).

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator attempted to interview three of five residents. The investigator contacted a family member, a guardian, and law enforcement. The investigation included review of the resident's medical records and alleged perpetrator's personnel file.

Resident #1
Resident #1 resided in an assisted living facility. Resident #1's diagnoses included dementia, depression, and anxiety. Resident #1's assessment, dated prior to the incident, indicated resident #1 was not oriented to person, place, or time. The assessment indicated resident #1 had a brain injury and displayed moments of forgetfulness with dates. The assessment indicated resident #1 was unable to manage finances, needed reminders to pay rent, and indicated a responsible party managed resident #1's finances. The assessment further indicated resident #1 had a history of being financially exploited.

An Authorization to Assist with Finances form indicated resident #1 did not have a guardian or conservator and listed the facility as a financial or representative payee. The form indicated the facility was responsible for resident #1's checking account and was approved to use resident #1's ATM/debit card. Resident #1 and a member of management had both signed the form.

Resident #2
Resident #2 resided in an assisted living facility. Resident #2's diagnoses included traumatic brain injury. Resident #2's assessment indicated resident #2 displayed moments of forgetfulness with dates, was unable to manage his finances, and had a representative payee to manage them.

Resident #3
Resident #3 resided in an assisted living facility. The resident's diagnoses included multiple sclerosis and Asperger's syndrome. Resident #3's assessment indicated resident #3 was forgetful, was a poor decision maker, and had a family member as a legal representative.

Resident #4
Resident #4 resided in an assisted living facility. The resident's diagnoses included traumatic brain injury and dementia. Resident #4's assessment indicated resident #4 was alert, forgetful, and had severe cognition impairments (problems remembering things and solving problems).

Resident #5
Resident #5 resided in an assisted living facility. The resident's diagnoses included traumatic brain injury, dementia, and mood disorder. Resident #5's assessment indicated resident #5 was forgetful, had poor short-term memory, was easily persuaded, influenced by others, and needed support with decision making. The assessment indicated resident #5 was unable to manage finances, the facility was his representative payee, and he had a guardian.

Law enforcement records indicated the alleged perpetrator collected resident #1's monthly rent of $1053.00 but failed to provide resident #1 with a receipt and the money was not in the safe where it was supposed to be. The record indicated a member of management contacted the alleged perpetrator and asked where the money was, the alleged perpetrator said the money was in her work bag and she would bring it in when she came back to work. The record indicated the alleged perpetrator never returned to work and after multiple communications

the alleged perpetrator told the member of management, she mailed the money to the corporate office. However, the money was never received at the corporate office.

Law enforcement records also indicated the facility had cash on hand for residents to use to purchase personal items. The report indicated a receipt, and any leftover cash was to be put back in the safe. The report indicated there was cash or receipts missing for the following: resident #2 for a total of $396.44, resident #3 for a total of $163.34, resident #4 for a total of $769.98, and resident #5 for a total of $460.81.

The facility's investigation included audits of the *Staff Individual Petty Cash Expenditure Sheet*, which showed residents #2, #3, #4, and #5 all had missing cash. The same documents indicated the alleged perpetrator had access to the residents' cash as part of her work duties.

The Program Manager job description, signed by the alleged perpetrator, indicated the position was a direct care / leadership position which included duties of reviewing individual finances monthly, reviewing the company credit card and house petty cash expenditures monthly for the location, and submitting the company credit card and house petty cash documents to finance by due date monthly.

Law enforcement records included an interview with the alleged perpetrator which indicated the alleged perpetrator admitted she had collected resident #1's rent of $1050.00. The alleged perpetrator stated she mailed the rent money, work keys, and two receipts for resident purchases to the corporate office. The alleged perpetrator further stated resident money is kept in a file cabinet in an office that is not locked, which everyone has access to.

In addition, law enforcement records indicated there were six purchases made to Amazon using a company credit card which was assigned to the alleged perpetrator. The purchases were shipped to the home address of the alleged perpetrator. The report indicated members of management stated items purchased with the company credit card should not be shipped to a private residence, the items were not things the facility used, and were not located at the facility.

During an interview, the guardian for resident #2, resident #4, and resident #5 stated she was not directly involved in the incident, but a member of management informed her of the incident. The guardian stated she did not discuss the incident with the residents because of their diagnoses and they fixate on things. The guardian stated the resident's do have trustees, but the facility was their representative payee.

During an interview, a member of management stated following some incidents the administrative staff became suspicious of the alleged perpetrator and completed audits on resident's petty cash. In the first incident the alleged perpetrator used company purchased Minnesota Wild tickets for personal use. The alleged perpetrator was supposed to bring residents to the game but told administrative staff she was visiting her ill grandma. A staff

member from administration decided to take the residents and when they arrived at the game, they found the alleged perpetrator and three other people in the assigned seats. The second incident was when she told administrative staff her grandmother passed away. No public obituary was found, and a family friend told administrative staff her grandma had not passed away. The third incident was when the alleged perpetrator failed to turn resident #1's cash rent payment of $1050.00 into the business office. Following the completion of petty cash audits, it was determined cash and/or multiple receipts were missing for items purchased for four residents in the total amount of $2843.57. The member of management stated after multiple attempts of collecting the cash rent payment, they never received it. In addition to the alleged theft from resident's the member of management stated they found Amazon purchases made by the alleged perpetrator for items the facility did not use that were delivered to her home address. The member of management stated they contacted law enforcement and filed a report.

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, for resident #3, resident #4, and resident #6. No, for resident #1, resident #2, and resident #5 related to medical or behavioral reasons.
Family/Responsible Party interviewed: Yes, for resident #1, resident #2, resident #4, and resident #5. No family member reached for resident #3. No family interview for resident #6 related to restraining order/family conflicts.
Alleged Perpetrator interviewed: No. Attempts were made but unsuccessful.

Action taken by facility:
The incident was investigated and turned over to law enforcement for investigation.

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
Washington County Attorney
Hastings City Attorney
Hastings Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28126	A. BUILDING: _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CHALLENGES INC - AFTON	6880 ST. CROIX TRAIL SOUTH HASTINGS, MN 55033

(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 July 6, 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 six (6) residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL281267375C / #HL281264383M, 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 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 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 evaluators ' 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 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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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: The facility failed to ensure five of six residents (R1, R2, R3, R4, and R5) reviewed were ree 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 required.	