

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL30391003M
Compliance #: HL30391004C

Date Concluded: August 4, 2022

Name, Address, and County of Licensee

Investigated:

VP at Garnette Gardens
511 South Dekalb Street
Redwood Falls, MN 56283
Redwood County

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

Evaluator's Name: Danyell Eccleston, 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), a staff member, financially exploited a resident when the AP stole narcotic medication, oxycodone, from the resident's supply.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. Video footage of the resident's apartment showed the AP stealing medication from the resident's apartment and the AP admitted to stealing

narcotic medication from the resident's supply on two different occasions during the time frame in question.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of medical records, surveillance video, employee records, and facility policies and procedures. The investigator also observed the resident's apartment and observed the prescribed oxycodone stored in the residents apartment.

The resident resided in an assisted living facility. The resident's service plan included assistance with bathing, dressing, housekeeping, and daily checks.

Review of video camera footage of the resident's apartment during the time frame in question showed the AP accessing the area where the resident stored the oxycodone, opening a pill bottle, removing pills from the bottle, and placing the pills in her pocket.

During an interview, a member of leadership stated the resident reported storing oxycodone pills in her apartment and two occasions the resident noted there were pills missing from her supply. The leadership member stated she reviewed camera footage that showed the AP removing a handful of pills from the resident's apartment. The leadership member stated the AP did not administer medications as part of her job at the facility and the resident managed her own medications.

During an interview, the AP stated she was prescribed the same narcotic pills as the resident and on two occasions stole pills from the resident. The AP stated she did not know how many pills she stole.

Review of the AP's employee file indicated the facility provided education to the AP about the Vulnerable Adult Act and the definition of maltreatment.

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

Family/Responsible Party interviewed: interview declined

Alleged Perpetrator interviewed: Yes

Action taken by facility:

The facility investigated the incident.

The AP is no longer employed by the facility.

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

Redwood County Attorney

Redwood Falls City Attorney

Redwood Falls Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30391	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/22/2022
NAME OF PROVIDER OR SUPPLIER VISTA PRAIRIE AT GARNETTE GARDENS		STREET ADDRESS, CITY, STATE, ZIP CODE 511 DEKALB STREET REDWOOD FALLS, MN 56283		
(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: #HL30391004C/#HL30391003M On July 22, 2022, 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 74 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL30391004C/#HL30391003M, 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
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was financially exploited. Findings include: On August 4, 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.		