Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL30438523M
Compliance #: HL304389880C

Date Concluded: December 26, 2023

Name, Address, and County of Licensee Investigated:
Cedars of Austin
700 1st Drive Northwest
Austin, MN 55912
Mower County

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

Evaluator's Name: Lissa Lin, 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 (AP) financially exploited a resident when he stole $1500 from the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP told law enforcement while he worked at the facility, he stole and forged a blank check from the resident. The AP deposited the $1500 dollar check to his bank account.

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 policies, procedures, the AP's personnel record, and resident records. Also, the investigator observed staff members entering resident rooms to clean or provide direct cares.

The resident resided in an assisted living facility. The resident's diagnoses included Parkinson's disease and age-related macular degeneration of both eyes. The resident's service plan included assistance with medication management and administration, toileting, transfer assistance and escorts to the memory care unit to visit his wife. The resident's assessment indicated he could communicate clearly and was easily understood.

On the resident's move-in day, his furniture did not arrive, so management let him use a guest room. The resident stored some of his personal belongings in the guest room, and some belongs in his intended room. The resident stayed in the guest room a few days until his furniture arrived. The AP was scheduled to work during that time.

A police report, shortly after the resident's admission, indicated a police officer from another city received a phone call from the resident reporting a stolen and fraudulently cashed check. The resident told police he balanced his checkbook and saw a $1500 check cashed that he did not write. The resident called his bank and had a copy of the forged check ready for police. The check was written out to the AP. The AP's credit union froze the $1500 in funds which were still in the AP's account.

A few days later, the AP called police about his frozen bank account and the forged check. The police report indicated the AP wanted to return the money to the resident and not have the police involved. When pressed by the police, the AP said he deposited a forged check in his name. The AP said he found the check, then said "I grabbed it from his living quarters. So essentially, I did steal it. Well, I did steal it. I am going to own up to that. I shouldn't have grabbed it in the first place." The AP said he had no money and was trying to figure out a way to get money. The AP did not recall what day he stole the check but told police the resident lived at the facility, and he was not in the room when the AP stole the check. The police forwarded the information to the local police department for review follow up and prosecution.

Review of the AP's personnel file indicated he completed training on Vulnerable Adult Compliance and Reporting.

During an interview, the manager said the resident's move in day was a "fiasco" due to bad weather and his furniture delivery delay. She said the resident used a guest room, so he had some place to sleep. There was a lot of staff back and forth between rooms with the resident's belongings, assisting with the move in. That was when the resident believed the blank check was stolen. The AP was the primary person who helped the resident. The resident discovered the missing $1500 while balancing his checkbook. He called police but did not notify facility staff about the theft. The manager said she found out when police called her and said a facility staff member admitted to stealing and forging the check. The manager said she immediately notified the corporate office, terminated the AP's employment, changed the building access code, sent the AP a no trespass notice and termination letter.

During an interview, the facility's compliance officer said the resident told the manager he was unable to pay his rent because of bank fraud but did not tell her someone had stolen a check from his room.

During an interview, the nurse said the AP had completed orientation and was a newer employee.

The AP did not respond to interview requests by phone and subpoena.

Court records indicated the AP was convicted of a gross misdemeanor for check forgery and placed on supervised probation for one year.

The resident declined an interview, but said he got the $1500 back and showed the investigator where he had stored the leather attaché case containing financial documents when the check went missing.

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;
(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

Vulnerable Adult interviewed: Declined a recorded interview.
Family/Responsible Party interviewed: Not Applicable.
Alleged Perpetrator interviewed: No, did not respond to phone calls and subpoena.

Action taken by facility:
The facility completed an internal investigation and changed door codes to the building. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
Mower County Attorney
Austin City Attorney
Austin Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	C 11/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER 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: #HL304389880C/#HL304385723M On November 13, 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 114 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL304389880C/#HL304385723M, tag identification 0620 and 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.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	C 11/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 620	Continued From page 1 (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	C 11/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 620	Continued From page 2 (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to report to the Minnesota Adult Abuse Reporting Center (MAARC) an allegation of theft for one of two residents (R2) reviewed. R2 reported $50.00 dollars missing from her purse. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2's diagnoses included dementia, diabetes type	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	C 11/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 620	Continued From page 3 2 and generalized anxiety disorder. R2's service plan dated June 8, 2023, indicated R2 received daily blood glucose monitoring, medication management and administration, and toileting assistance as needed. An incident report dated September 28, 2023, indicated R2 reported to director of nursing (DON)-B she had a $50.00 bill and a $20.00 bill in her purse on a day when she went to the store. The next day R2 indicated she asked unlicensed personnel (ULP)-D to put her medications into her purse before a clinic visit. The following day R2 could not find the $50.00 bill. Licensed assistant living director (LALD)-A conducted an internal investigation that included staff interviews and review of camera footage showing staff (unnamed) enter R2's room for one minute while R2 was in her room. ULP-D indicated she put R2's pills into her purse as she asked, but she did not see any money in R2's purse and did not take any money from R2. Law enforcement was notified and they interviewed residents and staff members. As of October 9, 2023 law enforcement had no additional information on the incident. LALD-A completed an incident report and indicated MAARC was contacted, but a list of MAARC reports requested by the MDH surveyor during the entrance conference at 10:00 a.m., November 13, 2023 did not include R2's missing $50.00 incident. During an interview on November 13, 2023, at 1:15 p.m., LALD-A said the police were called about R2's allegation but she was unsure if a MAARC was filed.	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	C 11/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
0 620	Continued From page 4 On November 21, 2023, at 8:26 a.m., the MDH surveyor emailed compliance officer (CO)-E requesting a copy of R2's MAARC report. On November 21, 2023 at 9:49 a.m., an email from CO-E to the MDH investigator indicated the licensee did not have a MAARC report for the alleged theft. Between LALD-A, DON-B and CO-E, each thought one of them had completed it. CO-E wrote the licensee has put a plan in place moving forward to ensure this would not happen again. A policy, titled Vulnerable Adult Reporting and Investigation, dated July , 2023, indicated if a crime occurred or is suspected, staff will take steps to preserve any evidence that may be needed in a police investigation and will contact 911/law enforcement. As soon as a client's safety is address, staff witnessing the maltreatment or the nurse in charge will notify MAARC. If it is unclear whether maltreatment has occurred, the director of health care, or executive director will make a report to MAARC. TIME PERIOD TO CORRECT: Seven (7) Days	0 620		
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 two residents reviewed (R1) was free from maltreatment.	02360	No plan of correction is required for this tag.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	C 11/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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
02360	Continued From page 5 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		