

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL305537564M  
**Compliance #:** HL305534182C

**Date Concluded:** November 20, 2023

**Name, Address, and County of Licensee**

**Investigated:**

Pleasant View Estates LLC  
41 Brand Avenue  
Faribault MN, 55021  
Rice County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Kris Detsch, 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 she accepted 25,000.00 dollars 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 worked in a leadership role while she was employed at the facility and developed a personal relationship with the resident outside of the boundaries of a professional relationship. Although the resident managed her own finances, her health status was failing, and she received hospice cares.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members and hospice providers. The investigation included review of resident records, and employee files. Also, the investigator toured the facility and observed interactions between staff and residents. The

resident resided in an assisted living facility. The resident's diagnoses included kidney disease, heart disease, arthritis, and chronic obstructive pulmonary disease (COPD). The resident's service plan included assistance with dressing, bathing, housekeeping, laundry, meals, and medication administration. The resident's nursing assessment indicated the resident was alert and able to communicate her needs. The resident managed her own finances, but her health was declining, and she received hospice services.

During an interview, the resident said her, and the AP became "very" close while the AP worked at the facility. The resident said the AP helped her after she fell, provided cares for her, and did extra things for her such as putting together her mechanical lift chair. The resident said the AP was "pushed out the door," and was no longer working at the facility. The resident said she obtained the AP's address from a card she received from the AP. She wrote a check and mailed it to her because the AP had children to provide for in addition to a new house, and car. The resident said after she mailed the check to the AP, facility staff talked to her and told her the AP should not receive money. The resident said she contacted her bank and confirmed the AP cashed the check. The resident said the AP did not return the money. The resident said the AP did not ask for money and she intended for the AP to receive it.

During an interview, a family member said the resident began to tell her personal information about the AP. The family member said the AP entered the resident's room and talked with her about her homelife. The family member said the resident became quite fond of the AP and it "tugged" at the resident. The family member said the AP told the resident way too much and beyond what a staff member should within a professional relationship. The family member said the resident sent the AP a note which expressed gratitude for the care she received from her with the check. The family member said prior to the incident, the resident wanted to donate the money to the facility, but ended up giving it to the AP. The family member said the resident was not wealthy and needed the money to pay for her care and they felt the AP "groomed" her and took advantage of her.

During an interview, a manager said the facility terminated the AP prior to this incident. The manager said when she terminated the AP, the resident was in a common area and observed her leaving the facility. The resident told the manager the AP informed her the facility would do this, and they were difficult to work for. The manager said the resident was upset and crying. The manager said the amount of money the resident wanted to donate to the facility, ended up being the same amount of money she gave to the AP. Additionally, it was the AP who told the manager the resident wanted to donate 25,000.00 dollars to the facility. The manager said the AP was overly involved in the resident's care.

During an interview, the AP said she was in a manager role while she worked at the facility. The AP said the resident had anxiety which caused the resident's blood pressure to rise, so she provided socialization. The AP said she provided one to one attention to all the residents at the facility and provided personal cares to the residents when other staff members were unable to work. The AP said she received the check after the facility terminated her. The AP said she took

the check to the bank, deposited the money into her account, and has spent most of the money. The AP said if she was working at the facility and the resident gave her money, she would not have accepted it, however she was no longer working for the facility, so it was different. The AP said she accepted the money because she needed it for a vet bill. The AP said she did not know if it was appropriate to accept the money from the resident. The AP said she did not talk to the resident about her financial difficulties, and said the resident continues to write her letters, but has not sent anymore checks. The AP said she did not know how the resident or family knew personal information about her except for the fact she had a new car because she missed a few days of work because her car broke.

Letter correspondence between the AP and the resident indicated the AP sent the resident a card after her termination. The note indicated the AP had a hard time the first couple of days and the resident could call her. The AP wrote her phone number in the card and indicated she would also send the resident pictures. The AP's address was on the envelope of the card. The AP wrote she loved and missed the resident. The resident sent the check to the AP three days later. Approximately one month later, the AP wrote another note to the resident. The note indicated the AP's children's sport events were in "full swing" and she has not been herself lately because her dog died. Additionally, she had a sick child, and a funeral to attend. The AP wrote she missed the resident. Letter correspondence further indicated the resident was sympathetic to the AP. The resident wrote the AP and expressed her concern and she wished she could hug her tight. The resident also indicated the reason the AP missed her because they had a special relationship. Letter correspondence continued and three months after the resident sent the AP the check, she wrote her, "I'd do anything for you!"

Financial records confirmed the resident wrote a check addressed to the AP for 25,000.00 dollars. A copy of the check confirmed the AP signed the back of the check and her bank received it four days later.

The AP's employee filed indicated she received education regarding professional boundaries and code of ethics regarding accepting money from residents.

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:** Yes.

**Family/Responsible Party interviewed:** Yes.

**Alleged Perpetrator interviewed:** Yes.

**Action taken by facility:**

The facility provided education to their employees.

**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

Rice County Attorney

Faribault City Attorney

Faribault Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30553</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/02/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PLEASANT VIEW ESTATES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>41 BRAND AVENUE FARIBAULT, MN 55021</b>
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(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	<p><b>Initial Comments</b></p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b></p> <p><b>#HL305537835C/#HL305534563M and #HL305534182C/#HL305537564M</b></p> <p>On October 2, 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 thirty-six residents receiving services under the provider's Assisted Living license.</p> <p>The following correction order is issued for <b>#HL305534182C/#HL305537564M</b>, tag identification 2360.</p>	0 000	<p>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 License Providers. 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 surveyors' findings is the Time Period for Correction.</p> <p><b>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.</b></p> <p><b>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</b></p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.</p>	
02360	<p><b>144G.91 Subd. 8 Freedom from maltreatment</b></p> <p>Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial</p>	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	<p>Continued From page 1</p> <p>exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>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.</p>	02360	No plan of correction is required for this tag.	