DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL30812001M
Compliance #: HL30812002C

Date Concluded: October 5, 2022

Name, Address, and County of Licensee Investigated:
The Waters of Eden Prairie
431 Prairie Center Drive
Eden Prairie, Minnesota 55344
Hennepin 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 the resident's store debit card and made multiple unauthorized transactions using the resident's card.

Investigative Findings and Conclusion: The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP stole the resident's store debit card and made multiple unauthorized transactions with six of the transactions totaling $1,383.64

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the financial power of attorney for the resident. The investigation included review of medical records, employee records, facility policy and procedures, store surveillance footage and images, unauthorized transaction receipts, resident account information, and police records.

The resident resided in an assisted living memory care unit with diagnoses including Alzheimer's disease. The resident's service plan included assistance with medical monitoring, bathroom assistance, bathing, medication management, dressing, safety checks, and escorts. The resident's cognitive assessment score was in the lowest category which indicated the resident had dementia and an additional assessment indicated the resident was confused, had impaired judgement, and was disoriented to person, place, and time.

During interview a member of facility leadership stated the facility was contacted by the resident's power of attorney due to multiple unauthorized charges being made to the resident's bank account through use of a credit card. The leadership member stated the resident resided on the memory care unit and would not have the ability to make purchases. The member of leadership stated around the time of the incidents, the AP stopped coming to work.

During interview, the resident's power of attorney stated she managed the resident's finances and noted the resident's checking account was completely empty when the account should have contained several thousand dollars. The power of attorney contacted the bank and discovered there were unauthorized charges made via a store debit card that was tied to the resident's checking account. The power of attorney contacted the facility and staff members discovered the resident's wallet only contained health information cards and a library card. The resident wallet should have also contained the resident's driver's license and credit cards. The resident's power of attorney indicated approximately 13 unauthorized transactions were made to the resident's credit card.

Review of store surveillance footage and images indicated the AP physically made purchases at multiple locations of a department store and six store receipts matched amounts charged to the resident's store debit card that totaled $1,383.64.

Review of law enforcement report indicated criminal charges of financial transaction card fraud related to the incident were filed against the AP. Law enforcement information identified the AP in surveillance footage and images from multiple locations of a department store as the individual making unauthorized purchases to the resident's store debit card.

During an interview, a nurse stated the AP was employed with the facility for approximately two months and primarily worked in the memory care area where the resident resided. The nurse stated staff members are not allowed to utilize resident credit or debit cards to make purchases.

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: No, resident cognitively impaired
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No, did not respond to multiple interview requests.

Action taken by facility:
Facility conducted review of belongings to ensure that responsible parties were aware of check books, credit cards, and debit cards that were in the possession of cognitively impaired residents that did not manage their own funds.
Facility re-educated staff members regarding resident abuse and reporting.

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
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
	30812	A. BUILDING: _____ B. WING _____	C 09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF EDEN PRAIRIE	431 PRAIRIE CENTER 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 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: #HL30812002C/#HL30812001M On September 15, 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 94 residents receiving services under the provider's /Assisted Living with Dementia Care license. The following correction order is issued for #HL30812002C/#HL30812001M, 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		

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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 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 October 5, 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.	