State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL31696001M
Compliance #: HL31696002C

Date Concluded: August 1, 2022

Name, Address, and County of Licensee Investigated:
Savage Senior Living
5950 West 130th Lane
Savage, MN 55378
Scott County

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

Evaluator's Name: Peggy Boeck 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) financially exploited a resident when the AP stole a blank check from the resident and cashed it without the resident's consent.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP stole a blank check from the resident, wrote it out for $3,940.45, and cashed the check. Bank surveillance video identified the AP as the person who cashed the check.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family, law enforcement, and the fraud department at the bank. The investigation included review of personnel records, resident medical records, resident financial records, bank surveillance photos, facility

documents, policies, and procedures regarding maltreatment of vulnerable adults, and care of resident property.

The resident resided in an assisted living facility due to diagnoses that included anxiety and heart failure. The resident's care plan included assistance with personal cares, wheelchair mobility, toileting, and safety checks.

According to a police report, a family member received an alert from the resident's bank. The alert notified the family member a $3940.45 check had been cashed. The family member verified with the resident he did not write the check. The family member filed a report with law enforcement and contacted the bank.

During an interview, a family member stated she thought someone must have stolen the resident's check, as the resident and other family members reported they did not write the check. The family member noted the handwriting on the check did not belong to the resident or the family member who helped the resident with his finances, and the signature included the residents nickname and last initial only. The family member spoke with the bank that cashed the resident's check and discovered that there was a second check that someone also tried to cash. The family member stated the bank flagged the resident's account to prevent anyone from cashing any more checks and closed the account. The family member also contacted the facility about the stolen checks.

During an interview, a facility management staff stated the AP had made requests to work in the assisted living when scheduled to work in memory care, which she felt was odd. The management staff suspected the AP was not completing work, so installed a camera, which revealed the AP sleeping in a memory care room in a resident's recliner. The management staff stated they terminated the AP due to sleeping on the job, failure to complete job tasks, and failure to report for work. The management staff stated she looked at a copy of the stolen check and compared the handwriting to the AP's, which lead her to believe the AP stole the checks.

During an interview, the resident stated the AP talked to him about playing basketball, and how the AP got hurt in college which ruined the AP's possibility of a professional basketball career. The resident stated the AP was nice to him and the resident felt bad about his situation. The resident stated he previously kept a few checks in his billfold in his drawer, and the AP would have no reason to go in there. The resident stated after the check was stolen, he could no longer keep his own checks and depended on others. The resident feared the situation was his fault.

According to the law enforcement investigation, a friend of the AP left his identification in the AP's vehicle and the AP would not return the identification. The friend filed a report with law enforcement, and they discovered the AP had used the friend's identification to open a bank account. The AP also used the identification to obtain a state ID. The AP wrote the resident's

check out payable to the friend's name and cashed it using the stolen identification. Bank surveillance identified the AP cashing the check. The friend identified the AP in the bank surveillance photo. The facility management staff identified the AP in the bank surveillance photo. Legal charges were pending at the time of the report.

In conclusion, financial exploitation occurred.

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.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No, the AP did not respond to requests for an interview or to a subpoena.
Action taken by facility:
The alleged perpetrator no longer works at the facility.

Action taken by the Minnesota Department of Health:
No further action taken.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Scott County Attorney
Dakota County Attorney
Burnsville City Attorney
Savage Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31696	A. BUILDING: ______ B. WING ______	C 06/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVAGE SENIOR LIVING	5950 WEST 130TH LANE SAVAGE, MN 55378

(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: #HL31696002C/#HL31696001M On June 6, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 105 clients receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL31696002C/#HL31696001M, tag identification 2360.	0 000	Minnesota Department of Health is documenting 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 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	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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SAVAGE SENIOR LIVING	**5950 WEST 130TH LANE** **SAVAGE, MN 55378**

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02360	Continued From page 1 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: 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 June 6, 2022, 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.	