Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL348129147M
Compliance #: HL348126864C

Date Concluded: November 22, 2023

Name, Address, and County of Licensee Investigated:
Lilac Homes Enhanced Assisted Living
1500 Southwood Drive
Dilworth, MN 56529
Clay County

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

Evaluator's Name: Barbara Axness, 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 Resident #1 when she used his debit card to make unauthorized purchases for herself.

The AP financially exploited Resident #2 when she used his credit card to make unauthorized purchases for herself.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP worked as an unlicensed personnel (ULP) at the facility and had access to Resident #1 and Resident #2's credit cards. The AP provided direct care and services to both residents in the weeks leading up to the debit and credit cards going missing. The AP was seen on surveillance footage using Resident #1's credit card to purchase $180.80 of household supplies at a retail store. The AP was wearing a name badge from the assisted living facility while making the purchase. The AP was also seen on surveillance footage

using Resident #1's credit card to purchase $325.156 of tires. The AP was seen on surveillance footage using Resident #2's credit card to make two purchases at another retail store.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement. The investigation included review of facility records including recent assessments, the resident service plans, and progress notes, bank records, and the police report. At the time of the onsite visit, the investigator observed care and services provided by staff in the facility.

Resident #1 resided in an assisted living facility. The resident's diagnoses included hemiplegia (paralysis of one side of the body), hemiparesis (a condition causing weakness or paralysis on one side of the body) and familial spastic paraplegia syndrome (an inherited neurological disorder causing progressive weakness and stiffness of the legs). The resident's service plan included assistance with dressing, grooming, bathing, transferring, and medication administration. The resident's assessment indicated the resident was dependent upon staff to perform most activities of daily living.

Resident #2 resided in an assisted living facility. The resident's diagnoses included chronic kidney disease and heart failure. The resident's service plan included assistance with dressing, grooming, bathing, and medication administration. The resident's assessment indicated the resident was dependent upon staff to perform most activities of daily living.

Resident #1

Bank statements for September 2023 indicated 19 unauthorized charges totaling $1,472.23 were made over a seven-day period. Charges on the debit card included $325.15 at a tire store, a total of $225 over seven transactions at a night club, and several other charges at clothing stores, gas stations, and fast food restaurants.

A police report for Resident #1 included surveillance footage identifying the AP using the resident's debit card at two locations. The AP was seen purchasing $325.15 of tires using the resident's debit card. The AP was seen purchasing $180.80 of household goods including sheets, candles, and storage bins, at a large retail store using the resident's debit card.

The resident's account was overdrawn due to the unauthorized charges, causing his September 2023 charges for the assisted living facility to not go through due to insufficient funds.

During an interview, the resident's power of attorney (POA) stated the resident told her he was missing his debit card and she figured it was just misplaced, but when she checked his bank account, she noticed a lot of charges were made after the card went missing. The POA stated she cancelled the card right away and informed the facility.

Resident #2

Credit card statements for Resident #2 indicated the most recent balance was $7,032.71. Of that balance, $1,907.31 was a cash advance at 29.99% interest. Charges on the card included $164.05 at a party supply store, $85.97 at a clothing store, and several charges at gas stations, liquor stores, fast food, big box retail stores, nail salons, cosmetic stores, cell phone stores, coffee shops, various clothing stores, and car washes. In total, over a three-month period, 125 unauthorized charges were made to the resident's credit card.

During an interview, Resident #2 stated he is legally blind so he cannot read his credit card statements. The resident stated he only used that card to charge books for his electronic tablet and thought it originally had a balance of around $2,000, so he was very surprised when his wife said it was $7,000.

Resident #2's wife stated since the credit card was only used to purchase electronic books, she had the account set up to automatically pay the minimum balance and one day when she looked at the statement, "it had gone all the way up to $7,000" and she "thought something had gone wrong here so I started to do some checking." The resident's wife stated the credit card was usually kept in a file cabinet, along with some cash to pay for haircuts, in the resident's room; when she went to look for the card it was not there and $70 in cash was also missing. Resident #2's wife stated she went to the bank branch and had them print out recent statements for her and she did not recognize any of the charges.

During an interview, facility management stated they were contacted by police a few months ago and asked to help identify a person pictured in surveillance footage using a stolen credit card. The person in the footage was wearing a facility name tag and was identified as the AP. Since the AP was a suspect in a crime, she was removed from the schedule and management tried to contact the AP to discuss the incident further. The AP did not return phone calls and was then terminated from employment at the facility. A few weeks later, a resident reported their credit card also had fraudulent charges and they suspected the AP was responsible. Shortly after that, another resident reported fraudulent credit card charges were made and money was missing from their room. Facility staff reported the concerns to the police and submitted MAARC reports for both residents.

In conclusion, the Minnesota Department of Health determined financial exploitation was substantiated for Resident #1 and Resident #2.

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: Yes
Alleged Perpetrator interviewed: Attempts to contact were unsuccessful. The AP did not respond to a subpoena request.

Action taken by facility:
The facility reported the incident to MAARC and contacted law enforcement and the AP was terminated. The facility reimbursed the $70 of cash taken from Resident #2.

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.

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
Clay County Attorney
Dilworth City Attorney
Dilworth Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34812	A. BUILDING: _____ B. WING _____	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC HOMES ENHANCED ASSISTED LIVING	1500 SOUTHWOOD DRIVE DILWORTH, MN 56529

(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: #HL348129147M HL348126864C On November 2, 2023, 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 32 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL348129147M HL348126864C, tag identification 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 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. 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 subd. 1, 2, and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 1 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 one residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the alleged perpetrator (AP) was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	