Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL37302001M
Compliance #: HL37302002C

Date Concluded: February 9, 2022

Name, Address, and County of Licensee Investigated:
Haven Homes Assisted Living
4848 Gateway Boulevard
Maple Plain, MN 55359
Hennepin County

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

Evaluator's Name: Michele R. Larson, 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.

Allegation(s):
It is alleged: The alleged perpetrator (AP) financially exploited three residents, (Resident 1, Resident 2, Resident 3) when she stole money from them. The AP stole $250.00 from resident 1, $200.00 from resident 2, and $130.00 from resident 3. In addition, other residents had money stolen, including resident (Resident 4). The AP stole three $50.00 restaurant gift cards ($150.00) from resident 4.

Investigative Findings and Conclusion:
Financial exploitation was substantiated. The AP was responsible for the maltreatment. Although the AP denied stealing money and the gift cards, she tried to use resident 4's gift cards at the restaurant a few days after the gift cards were reported stolen. No further incidents involving financial exploitation occurred after the AP stopped working at the facility.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, the vulnerable adults, and family members. In addition, the

investigator contacted law enforcement. The investigation also included review of the resident's medical records and the AP's personnel record.

Resident 1 resided in the assisted living section of the facility and received no services. Resident 1 had a contract for housing only.

Resident 1's incident report indicated the day after resident 2 reported she was missing $200.00, resident 1 reported to the facility she was missing $250.00 from her wallet which she kept inside her purse in a bedroom closet.

Resident 2 resided in assisted living section of the facility. Resident 2's diagnoses included hypothyroidism and bilateral below the knee (BTK) amputee. Resident 2's service plan indicated resident 2 received supportive services and required assistance with escorts. Resident 2 used a manual wheelchair for mobility and a two-wheeled walker for assistance with walking.

Resident 2's incident report indicated one summer day resident 2 reported to a family member she was missing $200.00 from her wallet. Resident 2 stated she noticed the money was missing two weeks earlier but waited to tell her family member and administration she was missing the $200.00. Law enforcement was notified.

Resident 3 resided in the assisted living section of the facility. Resident 3's diagnoses included non-rheumatic aortic valve stenosis, chronic obstructive pulmonary disease (COPD), and pre-diabetes. Resident 3's service plan indicated resident 3 received assistance with personal cares, medication management, compression stockings, and monitoring her blood sugars. Resident 3 walked using a four-wheeled walker.

Resident 3's incident report indicated the same day resident 1 reported missing money, resident 3 reported she was missing $130.00 from a drawer located in a wooden filing cabinet inside her apartment. Resident 3 stated she last saw her money the month before.

The facility notified law enforcement and filed a Minnesota Adult Abuse Reporting Center report of the thefts of resident 1, resident 2 and resident 3.

Resident 4 resided in the assisted living section of the facility. Resident 4's diagnoses included generalized anxiety disorder, difficulty walking, hemiplegia, and hemiparesis (paralysis) following a cerebral infarction (stroke). Resident 4's service plan indicated resident 4 received supportive services. Resident 4 used a manual wheelchair for mobility.

The facility's internal investigation report indicated the internal investigation was started weeks earlier after other residents reported their money was missing. The internal investigation included interviews with residents, staff, and family members. A detective from law enforcement came to the facility and interviewed staff and residents. The facility, in

cooperation with family members, placed hidden cameras around a purse with money inside, hoping to catch the person responsible for the resident's stolen money. The planted purse and money remained untouched. The facility management reviewed staff video footage and found no suspicious activity. The facility re-educated staff on maltreatment and reporting. Staff signed documents acknowledging they understood the maltreatment and reporting procedures.

Two weeks later, resident 4 reported she was missing three $50 gift cards she purchased from a local restaurant. The internal investigation report indicated resident 4 documented the date and the amount of the purchase in her checkbook. An administrative staff person called the restaurant owner to report the stolen gift cards. The restaurant flagged the gift cards as stolen. The administrator requested the restaurant take a photo and obtain the names of the person or persons who attempted to use the stolen gift cards.

The facility's internal investigation indicated the AP, who was an unlicensed personnel, attempted to use the stolen gift cards four days after resident 4's gift cards were reported stolen. The AP was having dinner at the restaurant with friends, including another employee from the facility. The AP attempted to pay for dinner using the stolen gift cards, but the restaurant owner informed the AP the cards were stolen. The restaurant owner never mentioned who owned the gift cards. The restaurant owner took a photo of the AP and her friends sitting at the restaurant table and sent the photo to facility administration for identification. Facility administration suspended the AP and the other employee after they identified them in the photo. The following business day, the AP and the other employee were asked to come to the facility to be interviewed by law enforcement.

The AP submitted her resignation notice, including documentation, prior to being interviewed by the detective.

During her interview with the detective, the AP stated she found the gift cards wrapped in a note underneath the windshield wiper on her vehicle after working an overnight shift. The AP stated she thought the gift cards were from a resident or their family. The note indicated the unknown person appreciated the AP. The AP handed the note over to the detective and stated she went through seven bags of garbage to find the note that came with the gift cards.

The AP's resignation letter indicated the AP wrote she was resigning from her direct care staff position due to being falsely accused of committing the thefts. The AP wrote she would be looked at as a "horrible person." In her resignation letter the AP wrote she would never do anything to jeopardize her job and loved the residents.

Email correspondence between the director of health services (DHS), and facility administration, the DHS indicated the AP called her after the incident crying, stating she would never steal and loved her job. The email indicated the AP told the DHS that the restaurant owner, "let it slip," the gift cards belonged to resident 4.

During the interview with the detective, the employee stated the AP told her the gift cards were a gift and stated the AP told her she found flowers on her vehicle with the gift cards. The employee stated after the AP was told by the restaurant the cards were stolen, the AP walked back to the table and told the employee and friends there was something wrong with the gift cards, stating the restaurant deactivated the cards and never mentioned the cards were stolen.

During an interview, resident 2 stated she had no further incidents of stolen money after the internal investigation concluded.

During an interview, resident 3 stated she had no further incidents of stolen money after the internal investigation concluded.

During an interview, a nurse stated she told the AP she should have reported and turned in the gift cards to the facility. The licensed staff person stated since the AP resigned, there have been no more thefts at the facility.

During an interview, the administrator stated the AP denied everything and appeared visibly upset during her interview with the detective. The administrator stated the AP somehow knew the gift cards belonged to resident 4, even though no one mentioned who the cards belonged to. The administrator stated the AP told them the restaurant owner told her the gift cards belonged to resident 4. The administrator stated she contacted the restaurant owner who denied ever telling the AP who owned the gift cards. The administrator stated the AP had been a good employee, stating she was reliable, working overtime and picking up extra shifts. The administrator stated the AP got along well with her co-workers. The administrator stated since the AP resigned, there have been no more thefts at the facility.

During an interview, the detective stated the AP appeared to be unconcerned and nonchalant during the interview with him. The detective stated he thought it was odd the AP resigned from her position prior to doing the formal interview to defend her position. The detective stated, “there were many holes in her story.” The detective stated there have been no reported incidents of theft at the facility since the AP resigned.

During an interview, the AP stated she loved working at the facility. The AP stated the facility was trying to, “pin something on me that I didn’t do,” and stated the facility did not care what they had, “put me through.” The AP stated she was trying to get full custody of her son and was not about to risk losing, “everything.” The AP stated she previously wrote bad checks when she was in her 20’s and stated that was the only negative finding in her background check. The AP stated she had never stolen, “anything in her life.” The AP stated she was never interviewed during the internal investigation. The AP stated she found the gift cards and note on her vehicle after she left work. The AP stated she should have told her supervisor about finding the gift cards on her vehicle. The AP stated she thought the gift cards were from a resident or family member and stated the restaurant owner told her the stolen gift cards belonged to resident 4. The AP stated she resigned from her position because she did not want her reputation “ruined”. The AP defined a vulnerable adult as someone who was taken advantage of, stating, “they have somebody there who was using them.”

In conclusion, 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:
(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:
(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or
(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.
(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. Two vulnerable adults were interviewed.
Family/Responsible Party interviewed: Yes. Three family members of the vulnerable adults were interviewed.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility implemented vulnerable adult retraining. The AP was immediately suspended after she was caught attempting to use resident 4’s stolen gift cards. The AP put in her resignation letter before she could be terminated 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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
Maple Plain City Attorney
Maple Plain Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37302	A. BUILDING: _____ B. WING _____	C 11/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES ASSISTED LIVING	4848 GATEWAY BOULEVARD MAPLE PLAIN, MN 55359

(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: On November 30, 2021, 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 46 clients receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL37302002C/#HL37302001M, tag identification 620, 630, 2360, and 3000.	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.	
0 620 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC), suspected maltreatment for one of four residents (R2) reviewed. R2 was financially exploited by a staff member who worked at the facility. 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) 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). Findings Include: R2's record indicated R2 admitted to the facility on December 29, 2020. R2's diagnoses included hypothyroidism and bilateral below the knee amputee. R2's service plan dated October 1, 2021, indicated R2 received supportive services. R2 used a manual wheelchair for mobility, and a two-wheeled walker for walking.	0 620		

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0 620	Continued From page 2 R2's Uniform Assessment Tool dated July 27, 2021, indicated R2 received escort assistance as needed (PRN). R2's assessment indicated R2's family member (FM)-E handled R2's finances. R2's incident report dated August 18, 2021, indicated R2 reported to FM-E she was missing $200.00 from her wallet. R2 indicated her wallet was inside her purse in her apartment. Law enforcement report dated, August 20, 2021, indicated on August 18, 2021, FM-E reported someone stole $200.00 from R2. The report indicated the facility was conducting an on-going investigation into numerous thefts involving several resident's stolen money. A MAARC report, dated August 20, 2021 at 1:45 p.m., indicated R2's theft was reported August 18, 2021. R2's Individual Abuse Prevention Plan (IAPP), dated October 1, 2021, indicated R2 was susceptible to financial exploitation due to living in a community where staff had access to her apartment. R2's IAPP indicated all staff who provided cares for R2 were trained on abuse, prevention, and reporting. R2's family was aware to remove valuables, (including money) out of sight and report any suspicions of theft to staff for further investigation, according to the facility's policies and procedures. The licensee policy titled, Abuse Prohibition-Assisted Living-Minnesota, updated June 4, 2021, indicated the licensee immediately reported all violations and substantiated incidents immediately to the state agency (oral or online report to MAARC), and all other required agencies. The policy defined immediately as soon	0 620		

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0 620	Continued From page 3 as possible, but not to exceed 24 hours after discovering the incident. TIME PERIOD TO CORRECT: Seven (7) days	0 620		
0 630 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update a resident's Individual Abuse Prevention Plan (IAPP) for one of four residents (R1) reviewed. R1 was financially exploited by an unlicensed personnel (ULP). 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) 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).	0 630		

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0 630	Continued From page 4 Findings Include: R1's record was reviewed. R1 was admitted to the facility on April 28, 2021. R1 received no services and was designated as having a contract for housing only within the facility. R1's IAPP, dated August 3, 2021, indicated R1 was assessed as having no susceptibilities to being abused by others including, financial exploitation, neglect, ability to report abuse or neglect, or abusing other vulnerable adults. Review of R1's incident report dated, August 19, 2021, indicated on August 18, 2021, R1 reported to the licensed assisted living director (LALD)-A, she was missing $250.00 from her wallet which she kept inside her purse in bedroom closet. Law enforcement were notified and the facility filed a MAARC report with the state. On January 10, 2022 at 10:00 a.m., LALD-A stated registered nurses (RN) performed initial and on-going assessments, stating from those assessments, resident service plans were developed, including IAPPs. LALD-A stated she was responsible for completing and updating residents IAPPs who had a contract for housing only within the facility. The licensee policy titled, Abuse Prohibition-Assisted Living-Minnesota, updated June 4, 2021, indicated after suspected maltreatment of a vulnerable adult, the housing director and RN would review, revise and implement their service plans and interventions to reduce the risk of other similar incidents. TIME PERIOD TO CORRECT: Seven (7) days.	0 630		

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02360	Continued From page 5	02360		
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: Based on interviews, and document review, the facility failed to ensure four of four residents (R1, R2, R3, R4) reviewed were free from maltreatment. R1, R2, R3 and R4 were financial exploited. Findings include: On February 9, 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 is required for tag 2360. Please refer to public maltreatment report (emailed separately) for details.	
03000 SS=D	626.557 Subd. 3 Timing of report (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,	03000		

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03000	Continued From page 6 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. (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:	03000		

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03000	Continued From page 7 Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC), suspected maltreatment for one of four residents (R2) reviewed. R2 was financially exploited by a staff member who worked at the facility. 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) 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). Findings Include: R2's record indicated R2 admitted to the facility on December 29, 2020. R2's diagnoses included hypothyroidism and bilateral below the knee amputee. R2's service plan dated October 1, 2021, indicated R2 received supportive services. R2 used a manual wheelchair for mobility, and a two-wheeled walker for walking. R2's Uniform Assessment Tool dated July 27, 2021, indicated R2 received escort assistance as needed (PRN). R2's assessment indicated R2's family member (FM)-E handled R2's finances. R2's incident report dated August 18, 2021, indicated R2 reported to FM-E she was missing $200.00 from her wallet. R2 indicated her wallet was inside her purse in her apartment. Law enforcement report dated, August 20, 2021, indicated on August 18, 2021, FM-E reported someone stole $200.00 from R2. The report	03000		

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03000	Continued From page 8 indicated the facility was conducting an on-going investigation into numerous thefts involving several resident's stolen money. A MAARC report, dated August 20, 2021 at 1:45 p.m., indicated R2's theft was reported August 18, 2021. R2's Individual Abuse Prevention Plan (IAPP), dated October 1, 2021, indicated R2 was susceptible to financial exploitation due to living in a community where staff had access to her apartment. R2's IAPP indicated all staff who provided cares for R2 were trained on abuse, prevention, and reporting. R2's family was aware to remove valuables, (including money) out of sight and report any suspicions of theft to staff for further investigation, according to the facility's policies and procedures. The licensee policy titled, Abuse Prohibition-Assisted Living-Minnesota, updated June 4, 2021, indicated the licensee immediately reported all violations and substantiated incidents immediately to the state agency (oral or online report to MAARC), and all other required agencies. The policy defined immediately as soon as possible, but not to exceed 24 hours after discovering the incident. TIME PERIOD TO CORRECT: Seven (7) days	03000		