Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL394446742M
Compliance #: HL394441240C

Date Concluded: February 28, 2025

Name, Address, and County of Licensee Investigated:
Presbyterian Homes Marvella
825 Mt Curve Blvd
St. Paul, MN 55116
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, RN, BSN, 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), a facility staff member financially exploited resident #1 and resident #2. The AP used resident #1's credit card and made unapproved charges and took resident #1's wedding ring. Resident #2 was financially exploited when the AP took $40.00 from the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. During the course of the investigation, it was discovered resident #1 and resident #4 had charges made on their credit card that totaled almost $5,000.00 from vendors used by the AP including apartment rent. Although resident #1 lost a wedding ring and cash, and resident #2, resident #3, resident #4 had cash taken from them, it could not be determined if the AP took the wedding ring and cash because of the uncertain time frame of the incidents, no witnesses, and the number of people that had access to the resident's apartments.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and a business owner where charges were made on resident #1's credit card. The investigation included review of the resident records, facility internal investigation, personnel files, tenant log sheet, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator made observations of staff and resident interactions during an onsite visit.

Resident #1 resided in an assisted living facility. Resident #1's diagnoses included a stroke. The resident's service plan included assistance with morning and evening cares. The resident's assessment indicated the resident had intact cognition and was independent with financial decisions.

Resident #4 resided in an assisted living facility. Resident #4's diagnoses included dementia. The resident's service plan included assistance with homemaking services. The resident's assessment indicated the resident had intact cognition and was independent with financial decisions.

Facility documents indicated one day, resident #1's family member notified facility leadership that resident #1's money clip containing cash, wedding ring, and a credit card were missing. At that time, Resident #1's credit card statement indicated 51 charges totaling $4,810.00 were made. The facility document indicated the police were notified.

The AP's payment ledger from the AP's apartment complex indicated the AP made an online payment with a credit card for $750.00. Seven days later, the AP made another online payment with a credit card for $500.00. Four days later, the AP made another online payment with a credit card for $150.00 The AP's payment ledger indicated all three payments were disputed (a consumer requested their credit card company remove an incorrect or fraudulent charge from their bill).

Resident #1's credit card statement indicated charges were made to an apartment complex with the same address as the AP. The same days as the tenant log sheet, resident 1's credit card indicated charges of $772.13, $514.75 and $154.43. In addition, resident 1's credit card had charges made to a nail salon, transportation companies, luxury wig store, hair salon, food delivery services, prepaid phone, handbag store, and a women's clothing website.

Correspondences between law enforcement and the apartment complex indicated the difference in amounts on the credit card statement and the amount on the AP's payment ledger is because additional processing charges were applied.

Resident #4's credit card statement had highlighted areas that indicated approximately $130.00 was spent on food and transportation similar to the charges made by the AP for resident #1.

During an interview, the human resource director stated they determined it was the AP, because resident #1's bank statement had a repeated charge to an apartment complex, the same apartment complex that the AP lived at. Human resources stated they called the apartment complex and spoke to a representative that confirmed the AP used a credit card to pay her rent. The AP also used resident #1's credit card at a luxury wig store, nail salon, and transportation companies.

During an interview, the resident service director stated during the investigation of resident #1's missing cash and credit card, it was discovered that resident #4 had received a letter from his bank that indicated suspicious charges were made on his credit card. Resident #4's credit card had similar charges as resident #1's charges on his credit card.

During an interview, the owner of the luxury wig store stated the AP was a client of the store and used a credit card to pay for the items that came back as disputed. The owner stated she did not remember the actual name on the credit card, but the name was not the AP's name.

During an interview, the AP denied stealing credit cards from residents.

Correspondence with law enforcement indicated charges for felony transaction credit card fraud would be made against the AP.

During an interview, resident #1's family member stated the resident does not leave the assisted living without assistance. The family member stated the charges on resident #1's credit card was not items resident #1 would have purchased.

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: Yes, all four residents were interviewed.
Family/Responsible Party interviewed: Resident #1 and resident #2's family member was interviewed. Resident #3 and resident #4 were their own person.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation, notified the police and suspended the AP. The AP is no longer employed by the facility.

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.

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

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
Ramsey County Attorney
St. Paul City Attorney
St. Paul Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39444	A. BUILDING: _____ B. WING _____	C 01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVELLA	822 WOODLAWN AVENUE SAINT PAUL, MN 55116

(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: #HL394446742M / #HL394441240C On January 27, 2025, 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 62 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL394446742M /#HL394441240C, 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 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 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: The facility failed to ensure two of four residents reviewed (R1 and R4) was free from maltreatment. Findings include: 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.	02360		