Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H15647985M, H15647965M, H15647984M
Compliance #: H15644783C

Date Concluded: February 26, 2024

Name, Address, and County of Licensee Investigated:
Essentia Health Hospice West
900 Hilligoss Boulevard Southeast
Fosston, MN 56542
Polk County

Facility Type: Hospice

Evaluator's Name: Willette Shafer, 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.

Initial Investigation Allegation(s):
The alleged perpetrators (AP) #1 and AP #2 financially exploited a client when AP #1 was added as a beneficiary to the client's bank account and withdrew all funds in the client's account. AP #2 removed all the client's personal belongings including his wallet from his room, after his death.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. AP #1 was responsible for the maltreatment. AP #1 was added to the client's bank account as an owner and as "payable on death" prior to the client's death. AP #1 withdrew all $4,412.69 from the client's bank account after the client died.

The Minnesota Department of Health determined financial exploitation was not substantiated against AP #2. AP#2 removed the client's belongings she had purchased for him (clothing) to donate after his death. AP #2 gave the client's neighbor his wallet after his death because the

neighbor helped manage his finances. There was no evidence AP #2 took money or other possessions from the client.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the police and client's family. The investigation included a review of client's medical records, financial institution records, internal investigation, personnel records, and agency policies.

The client lived at home and received home care services. As the client's health declined, he moved to a skilled nursing home and hospice services began. The client's diagnoses included heart disease, kidney disease, and diabetes. The client's service plan included assistance with wound care, medication management including continuous oxygen, meals, grooming, dressing, transferring, and housekeeping.

According to the financial institution's Consumer Account Agreement, AP #1 was added as the payable on death beneficiary three years before the client died. AP #1 signed the account and withdrew all funds after the client died.

During an interview, AP #1 said she provided care to the client for years and often outside of work time. She bought personal items for client, and he reimbursed her. AP #1 denied being a beneficiary on client's bank account. AP #1 said she was unaware the client put $4,400 in a bank with her name on it. The agency educated AP #1 on boundaries and appropriate relationships between clients and caregivers. She said she took the $4,400 out of the bank after the client died. AP #1 had medical issues that caused poor judgment. AP #1 returned the money to her supervisor, but they told her to keep it. She denied having written permission to keep the money. She said she still had the money.

During an interview, a member of management said the agency provided home care services to the client for many years. AP #1 worked for the agency and provided care to the client. The agency found out AP #1 helped the client after working hours. At that time, the agency removed AP #1 from the client's care. After the client died, the agency discovered AP #1 was the beneficiary on the client's bank account. AP #1 told the agency she was unaware she was listed as the beneficiary. The client's family notified the agency that AP #1 withdrew all the money from the client's account. The family submitted the bank statements that indicated AP #1 withdrew the money. AP #1 declined to give the money back to the family, so the agency repaid the family over $4,000. The agency notified law enforcement of the incident. The member of management said AP #2 removed the client's belongings from his room after he died. AP #2 removed his wallet and gave it to the neighbor who assisted the client with managing his finances. AP #2 said she paid for the client's belongings with her personal money and felt she was able to give it away after he died. AP #1 and AP #2 no longer work at the agency.

During an interview, a family member said AP #1 provided care to the client in his home. AP #1 was added as the beneficiary to the client's account. The client's family member believed the

client was coerced by AP #1 to add her to his account. AP #1 withdrew $4,412 from his account after he died. The family member stated they were reimbursed $4,412 by the agency. AP #1 admitted she withdrew the money from client's account.

During an interview, a nurse said the client received home care services from the agency for many years. When the client transferred to hospice care at the skilled nursing home, the agency noticed the client's medical record had AP #1 listed as the emergency contact. After the agency identified this, the agency removed AP #1 from his care. The nurse said she addressed boundary concerns with AP #1. AP #1 verbalized understanding of appropriate boundaries.

AP #1's personal record indicated AP #1 signed and dated education on "Home Care Handling Patient Finances and Property," agency code of conduct, one month prior to withdrawing money from the client's bank account.

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, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes, AP #1. No, AP #2 did not respond to interview requests.

Action taken by facility:
The agency completed an internal investigation and reimbursed family. AP #1 and AP #2 no longer work for the agency.

Action taken by the Minnesota Department of Health:

MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility 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. You may also call 651-201-4200 to receive a copy via mail or email.

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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
Polk County Attorney
Fosston City Attorney
Fosston Police Department

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH HOSPICE WEST	**900 HILLIGOSS BLVD SOUTHEAST , FOSSTON, Minnesota, 56542**

(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) COMPLETION DATE
40000	Initial Comments The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H15647965M, H15647985M, H15647984M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.	40000		
40400	HANDLING OF PATIENTS' FINANCES AND PROPERTY CFR(s): 4664.0040 Subp. 3-4 Subp. 3. Security of patient property. A licensee must not borrow a hospice patient's property, nor in any way convert a hospice patient's property to the licensee's possession, except in payment of a fee at the fair market value of the property. Subp. 4. Gifts and donations. Nothing in this part precludes a licensee or its staff from accepting bona fide gifts of minimal value or precludes the acceptance of donations or bequests made to a licensee that are exempt from income tax under section 501(c) of the Internal Revenue Code of 1986. This LICENSURE REQUIREMENT is NOT MET as evidenced by: The facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. 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.	40400		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE