*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL200228968M
**Compliance #:** HL200226497C

**Date Concluded:** March 26, 2024

**Name, Address, and County of Licensee Investigated:**
New Perspective of Roseville
2750 N Victoria St
Roseville MN 55113
Ramsey County

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

**Evaluator's Name:** Maggie Regnier
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 multiple residents when she took their credit or debit cards and used them to buy personal items for herself.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. Law enforcement conducted an investigation which included security camera footage from locations in which unauthorized purchases occurred and showed the AP present.

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 resident records, employee records, facility policies and police records. Also, the investigator observed interactions between staff and residents and visitors.

The AP worked full time at the facility for approximately a year as a housekeeper, which was a role that allowed the AP to all the resident's rooms for cleaning purposes.

Resident #1 resided in an assisted living facility. The resident's diagnoses include Huntington's disease (progressive breakdown of the nerve cells in the brain) and suffered from chorea movements (unpredictable and involuntary irregular muscle movements). Resident #1's service plan includes assistance with all daily living activities including dressing, bathing, and eating. The assessment indicated resident #1 understood others and was able to communicate but speech was difficult to understand.

Resident #2 resided in an assisted living facility. Resident #2' diagnoses include type II diabetes, epilepsy, and stroke. The service plan indicated resident #2 required with dressing and grooming and stand by assistance with transferring from chair to bed. The resident has some difficulty with speech because of the stroke but was understandable and able to communicate needs.

Resident #3 resided in an assisted living facility. Resident #3's diagnoses include osteoarthritis, peripheral vascular disease, and irritable bowel syndrome. The service plan indicated resident #3 required assistance with medication management and housekeeping. The resident has normal speech, understood others and was able to communicate needs.

All three residents reported irregularities on their personal financial statements regarding credit and/or debit cards. Subsequently, the facility contacted local law enforcement.

The law enforcement documents indicated police officers and investigators reviewed the allegations of unauthorized charges on these 3 residents' debit or credit cards. The same documents indicated the officers contacted the stores where unauthorized charges occurred and reviewed surveillance video which showed the AP and her vehicle in some instances at these locations. In at least one instance, the AP used the resident's cards for paying for purchases but used the AP's personal customer account at the store to earn purchase points. According to the police report, the AP was identified by her employer due to hair color and distinctive clothing.

These documents indicated the following amounts in fraudulent charges made by the AP for each respective resident.

Resident #1: $320
Resident #2: $1,180.11
Resident #3: $1,025.82

During an interview, a member of management stated she viewed images from the surveillance video from the police investigator and it looked like the AP and her clothing which included a t shirt distributed by the facility which was specific to the facility and only a few employees had.

The manager stated the AP had worked at the facility for about 11 months and after her employment was discontinued no more similar events occurred.

During an interview, an additional manager stated they view the surveillance video and stated the looked like the AP.

During an interview, the registered nurse also verified that the AP had education about maltreatment and what included maltreatment, like financial exploitation, as well as acceptable conduct to work at the facility.

During an interview, resident #1 stated they did not give anyone authority to make the fraudulent charges on her cards.

The facility's internal investigation indicated resident #2 said she did not give anyone authority to use her debit or credit card.

During an interview, resident #3 stated she did not authorize the fraudulent charges on her card and was very upset this happened to her. She stated she had been uncomfortable with the AP in her apartment unless resident #3 was also present prior to these events. However, the AP did not abide by this request and resident #3 believed the AP had accessed her wallet on multiple occasions.

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
**Family/Responsible Party interviewed**: No, residents are responsible for themselves.
**Alleged Perpetrator interviewed**: attempted multiple times.

**Action taken by facility:**
The facility terminated the AP and reported the incidents to the police department.

**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
Ramsey County Attorney
Roseville City Attorney
MN Department of Human Services

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 20022 | A. BUILDING: _____ B. WING _____ | C 02/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW PERSPECTIVE - ROSEVILLE | 2750 NORTH VICTORIA STREET ROSEVILLE, MN 55113 |

| (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<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL200226497C/#HL200228968M and HL200224977C<br><br>On February 20 2024, 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 87 residents receiving services under the provider's Assisted Living with Dementia Care license.<br><br>The following correction order is issued/orders are issued for #HL200226497C/#HL200228968M, 2360 tag identification .<br><br>No order are issued for HL200224977C. | 0 000 | | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>Residents have the right to be free from physical, | 02360 | | |

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| 02360 | Continued From page 1<br><br>sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure three of three resident reviewed (R1, R2 R3) were free from maltreatment.<br><br>Findings include:<br><br>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual 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. Please see publice maltreatment report for details. | |