Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Heritage House Assisted Living	HL20177004	December 14, 2017
Facility Address:	**Time of Visit:**	**Date Concluded:**
5825 St. Croix Avenue	8:30 am to 3:15 pm	March 14, 2018
Facility City:	**Investigator's Name and Title:**	
Golden Valley	Earl F Bakke, RN, Special Investigator	

State:	ZIP:	County:
Minnesota	55422	Hennepin

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that client #1 was financially exploited when alleged perpetrator (AP) took several pieces of the client's jewelry valued over $3,000.00 and sold it at a pawn shop. In addition, client #2 was financially exploited when AP went into client #2's jewelry box and stole jewelry.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on the preponderance of evidence, the allegation of financial exploitation is substantiated. The alleged perpetrator stole jewelry from client #1, client #3 and client #4 and others, based on his/her admission to law enforcement detectives. The AP sold the jewelry to a pawn shop for extra income.

Client #1 received services from the comprehensive home care provider for status checks, meals, bed and linen changes, and escorts by a resident aide when needed.

Client #2 received services from the comprehensive home care provider for medication reminders, assistance with activities of daily living, and housekeeping.

Client #3 received services from the comprehensive home care provider for medication management, house keeping, and meals.

Client #4 received services from the comprehensive home care provider for assistance with daily living activities, medication management, and meals.

Client #1 notified a family member about several pieces of jewelry missing from his/her apartment. Client #1 stated they had come home and discovered the door partially open on numerous occasions. Client #1 contacted law enforcement who began an investigation. A search of the Minnesota Pawn System (MPS) show a piece of jewelry matching a description from client #1. Law enforcement discovered client #1's jewelry had been pawned and the person who had sold the jewelry to the pawn shop had been identified as the alleged perpetrator (AP). Based on the MPS, law enforcement verified that the AP had pawned over 150 items over the last 1.5 years. Client #1 identified his/her jewelry from photograph taken by law enforcement. Law enforcement met with facility management and verified that the AP was an employee of the facility. The AP was stopped driving a vehicle near the facility, was arrested, and charged with felony possession of stolen property. The estimated value of client #1's jewelry was $4,000.00.

Law enforcement interviewed the AP. The AP admitted to law enforcement that he/she had been stealing items from clients for approximately one year. The AP said he/she saw the thefts as a way of earning extra money and that he/she had only stolen jewelry pieces. The AP named three other clients as person he/she had stolen from in the past and had stolen items from another facility he/she worked.

Law enforcement recovered over 40 pieces of jewelry. Law enforcement identified client #3 and client #4 as victims during the AP interview. Client #3 and Client #4 were able to identify several pieces of the jewelry law enforcement recovered as belonging to them. Client #2 had reported a missing ring, but it has not been recovered as of the date of this report. Law enforcement's investigation is continuing based on the number of items the AP had pawned.

During an interview with facility management, facility management said that law enforcement had notified the facility of their findings and that the AP would be charged with multiple alleged felonies. The AP's employment was terminated as a result of violating facility policies in regard to theft and financial exploitation of a vulnerable adult.

During an interview with client #1, he/she said that on several occasions he/she had returned to his/her apartment to find the door ajar. Client #1 had discovered several pieces of his/her jewelry missing while getting ready for an event outside the facility. A week later, the same thing happened, and this time a single piece of jewelry was missing. While at a facility event, client #1 had told client #2 about the missing jewelry.

Client #2, having been told about missing jewelry, checked his/her jewelry box and discovered a ring missing. Client #2 notified management and law enforcement. Client #2's jewelry has not been recovered as of the date of this report.

The AP was contacted on numerous occasions but did not reply to conduct an interview. The AP did not respond to a subpoena that had been served.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☐ Neglect ☒ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Click Here and Type

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☐ Facility is responsible for the

☐ Abuse ☐ Neglect ☒ Financial Exploitation. This determination was based on the following:

A background check was completed and showed cleared for employment. The AP received and completed training on vulnerable adult act laws and rules. The AP received a copy of the client's bill of rights, along with a copy of the employee handbook that addresses code of conduct.

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.

Compliance:

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 9 - Financial exploitation

"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;

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Care Guide
- [x] Assessments
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Service Plan

Other pertinent medical records:

- [x] Police Report

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Four

Were residents selected based on the allegation(s)? (●) Yes ( ) No ( ) N/A

Specify: ____________________

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

(●) Yes ( ) No ( ) N/A

Specify: ____________________

Interviews: The following interviews were conducted during the investigation:

Interview with reporter(s) (●) Yes ( ) No ( ) N/A

Specify: ____________________

If unable to contact reporter, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: (●) Yes ( ) No ( ) N/A Specify: ____________________

Did you interview the resident(s) identified in allegation:

(●) Yes ( ) No ( ) N/A Specify: Clients #1 and #2

Did you interview additional residents? (●) Yes ( ) No

Total number of resident interviews:Four

Interview with staff: (●) Yes ( ) No ( ) N/A Specify: ____________________

Tennessen Warnings

Tennessen Warning given as required: (●) Yes ( ) No

Total number of staff interviews: Three

Physician Interviewed: ( ) Yes (●) No

Nurse Practitioner Interviewed: ( ) Yes (●) No

Physician Assistant Interviewed: ( ) Yes (●) No

Interview with Alleged Perpetrator(s): ( ) Yes (●) No ( ) N/A Specify: ____________________

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:
12/15/2017	09:00:00 AM	112/19/2017	09:00:00 AM	12/26/2017	09:00:00 AM

If unable to contact was subpoena issued: (●) Yes, date subpoena was issued 12/26/2017 ( ) No

Were contacts made with any of the following:

☐ Emergency Personnel ☒ Police Officers ☐ Medical Examiner ☐ Other: Specify ____________________

Observations were conducted related to:

[X] Dignity/Privacy Issues

[X] Safety Issues

[X] Facility Tour

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: ____________________

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Golden Valley Police Department

Hennepin County Attorney

Golden Valley City Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20177	A. BUILDING: ______ B. WING ______	C 01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE ASSISTED LIVING	**5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422**

(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****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On December 14, 2017, a complaint investigation was initiated to investigate complaint #HL20177004 . At the time of the survey, there were 47 clients that were receiving services under the comprehensive license. The following correction orders are issued.	0 000		
0 325 SS=E	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interview and document review, the	0 325		

Minnesota Department of Health

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0 325	Continued From page 1 licensee failed to keep three of six clients (C1, C3, and C4) reviewed free from maltreatment when a staff member stole jewelry from the clients and sold the pieces to a pawn shop. This occurred as a Level 2- a violation that did not harm a client's health or safety (but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death) and at a pattern (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive). The findings include: C1's medical record was reviewed. C1's service agreement, dated September 5, 2017, indicated C1 received services from the comprehensive home care provider for meals, personal laundry, status checks, and wheelchair escorts when needed. A police report dated October 29, 2017, indicated C1 discovered jewelry missing from her room and called law enforcement. A law enforcement officer investigated the case and discovered C1's jewelry had been sold at a pawn shop. The value of the stolen jewelry was $4,000.00. The law enforcement officer identified the person who sold the stolen jewelry as a resident aide (RA)-G who worked for the licensee. Most of C1's jewelry was recovered from the pawn shop. A law enforcement detective continued the investigation and arrested RA-G possession of Stolen property. The police report indicated RA-G confessed to stealing jewelry from multiple clients over a period of a year and a half and named several of the clients he/she had stolen	0 325		

Minnesota Department of Health

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0 325	Continued From page 2 from during that time. RA-G told law enforcement that he/she had stolen to earn extra income. During an interview with C1 on December 14, 2017 at 10:06 am, C1 stated that he/she was getting ready for church and went to put on some jewelry. C1 noticed that multiple pieces of jewelry were missing. C1 also stated that the apartment's door had been found ajar several times, but she had discounted it because of accidentally leaving the keys in the doors on occasion. On a second occasion, C1 discovered the door ajar again and said that he/she was sure it had been closed. On that occasion, C1 discovered a particular piece of jewelry missing. C1 had called the police and was working with a law enforcement detective on the case. C1 said that numerous pieces of jewelry had been recovered from the pawn shop after she positively identified them as his/hers. C3's medical record was reviewed. C3's service agreement, dated October 30, 2017, indicated C3 received services from the comprehensive home care provider for medication administration, meals, and status checks. A police report, dated December 5, 2017, indicated C3 had identified several pieces of jewelry as being stolen and pawned by RA-G. RA-G was being charged with possession of stolen property. C3's family members had also tentatively identified pieces of jewelry as belonging to C3. C4's medical record was reviewed. C4's service agreement, dated January 13, 2017, indicated C4 received services from the comprehensive home care provider for medication administration and set-up, meals, and assistance with activities of	0 325		

Minnesota Department of Health

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0 325	Continued From page 3	0 325		

daily living.

A police report, dated November 11, 2017, indicated law enforcement made contact with C4 based on statement made by RA-G during a law enforcement interview. C4 identified a piece of jewelry with a pendant as being his/hers and stolen from his/her apartment. RA-G was charged with possession of stolen property this piece of jewelry also.

During an interview with the Assisted Living Director (A), he/she said that law enforcement had notified the licensee of the stolen jewelry investigation and the Assisted Living Director (A) had confirmed RA-G's employment. The Assisted Living Director (A) said RA-G employment was terminated due to the thefts and violating the vulnerable adult abuse policy.

A document titled, "Exhibit I Resident Rights", undated, states in part, "clients have the right to be treated with courtesy and respect, and to have the client's property treated with respect and the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act".

TIME PERIOD FOR CORRECTION:
TWENTY-ONE (21) DAYS

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 70150640000458709985

March 13, 2018

Mr. Jim Angell, Manager
Heritage House Assisted Living
5825 St Croix Avenue
Golden Valley, MN 55422

RE: Complaint Number HL20177004

Dear Mr. Angell:

A complaint investigation (#HL20177004) of the Home Care Provider named above was completed on January 19, 2018, for the purpose of assessing compliance with state licensing regulations. At the time of the investigation, the investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these regulations. These state licensing orders are issued in accordance with Minnesota Statutes Sections 144A.43 to 144A.482.

State licensing orders are delineated on the attached State Form. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by."

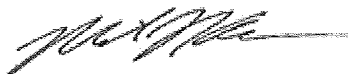
A written plan for correction of licensing orders is not required. Per Minnesota State Statute 144A.474 Subd. 8(c), the home care provider must document in the provider's records any action taken to comply with the correction order. A copy of this document of the home care provider's action may be requested at future surveys.

A licensed home care provider may request a correction order reconsideration regarding any correction order issued to the provider. The reconsideration must be in writing and received within 15 calendar days. Reconsiderations should be addressed to:

Renae Dressel, Health Program Rep. Sr
Home Care Assisted Living Program
Minnesota Department of Health
P.O. Box 3879
85 East Seventh Place
St. Paul, MN 55101

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Mike Kaehler
Health Regulations Division
Supervisor Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4181 Fax: (651) 281-9796

MK

Enclosure

cc: Home Health Care Assisted Living File
Hennepin County Adult Protection
Office of Ombudsman
MN Department of Human Services