Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202572344M
Compliance #: HL202571410C

Date Concluded: April 19, 2024

Name, Address, and County of Licensee Investigated:
Assisted Living at North Ridge
5500 Boone Avenue N
New Hope, MN 55428
Hennepin County

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

Evaluator's Name: Lena Gangestad, 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, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) financially exploited the resident by taking the resident's blank checks and writing checks to herself. The total amount was $3,600.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP took the resident's checks, forged the resident's signature, and wrote herself three checks.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of resident's records, the AP's personnel files, facility's policies and procedures, incident reports, and staff schedules, law enforcement report.

The resident resided in an assisted living building. The resident’s diagnoses include mild cognitive impairment.

The facility’s internal investigation indicated the AP wrote checks to herself and signed the resident's name. The resident was transferred to the nursing home part of the campus, but many of her personal belongings remained in her assisted living apartment for a few months. When the family came to retrieve her personal belongings, they discovered checks were missing and an investigation was initiated. No one in the family authorized these checks, and law enforcement was called.

The police report indicated the family member discovered some checks were missing from the resident's apartment and cashed. The family member told the police officer the signatures on these checks did not match the resident's signature. They showed the police officer a check with the resident's real signature, which did not match the signatures on the stolen checks. The same document indicated a review of the checks were written to a name used by the AP. The facility shared schedules, which indicated the AP worked evening shifts during the time period the checks went missing and had access to the resident’s apartment. The facility had samples of the AP’s writing/signature and felt the handwriting was similar when compared to the checks. The facility placed the AP on leave while the investigation was conducted. The police report indicated the police officer interview the AP, who stated she had not interacted with the resident and had never been in her apartment. The AP said the resident did not live there when she began working as a medication passer. The AP identified her bank but said she did not check her account frequently. Initially, she denied knowing about any checks, but later said she could not recall receiving money from anyone. The AP later contacted the police officer to report noticing a few deposits from the resident's account.

During an interview, a manager stated the resident had moved to the skilled nursing home six months prior. The manager stated the family came later to clean out her room and informed the manager that someone had stolen the resident’s checks. Upon investigation, the manager learned the one of the facility employees, the AP, was involved. She stated the AP had written the check to herself without authorization from the family. The manager immediately contacted the police and attempted to question the AP over the phone since the AP refused to come to the facility for a discussion. The AP claimed to be confused and unsure of how the situation had occurred. To verify, the manager compared the AP’s signature on official documents with the unauthorized check, finding them quite similar. The stolen amount was reported to be $3600 from the resident’s bank account.

During an interview, a family member stated the resident had moved to a different building a while ago. The family member stated he noticed two significant withdrawals from the resident’s bank account which he did not recognize nor was authorized the resident. Upon discussing this with the facility's manager, he discovered another unauthorized check for $600 was pending. He reported to the bank, and they refunded the entire amount of $3600. When the family member cleaned out the resident's old apartment, he found one check pads was missing.

According to the family member, the AP claimed the resident had given her a check and authorized her to write whatever she needed. However, when questioned, the resident denied ever meeting the AP or knowing who she was.

During an interview, the AP stated she worked as a medication passer at the facility for four months. The AP said she knew the resident and told the resident about the loss of one of her family members. According to the AP, the resident then offered her money. She said the resident gave her three blank checks and told her to fill in the desired amounts. However, the AP could not recall the specific day when the resident gave her the checks. She admitted to receiving the checks from the resident totaling $3000. The AP said she did not know she was not supposed to receive money from the resident. She also said the family contacted the police and retrieved the money from her 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: … [omit section a unless there is a fiduciary element]
(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;
(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: Attempts unsuccessful.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility reported to the police, the AP was placed on suspension pending investigation and subsequently her employment was terminated.

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
Hennepin County Attorney
New Hope City Attorney
New Hope Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	C 03/27/2024

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ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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0 000	Initial Comments On March 27, 2024, the Minnesota Department of Health initiated an investigation of complaint HL202579486M/HL202577230C and HL202572344M/HL202571410C. The following correction orders are issued For HL202579486M/HL202577230C correction order identification 0730, 1620 and 2360. For HL202572344M/HL202571410C correction order identification 2360.	0 000		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the	0 730		

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0 730	Continued From page 1 resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document services were provided as identified on the service plan for one of one resident (R1). 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, but was not likely to cause serious injury, impairment, or death), 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). The findings include:	0 730		

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0 730	Continued From page 2 R1 admitted to the licensee's facility on March 11, 2022. R1's diagnoses included muscle weakness and difficulty walking. R1's Kardex record, undated, indicated that R1 was incontinent and managed both independently and by staff. It also indicated bathing assistance once per week on Tuesday mornings. R1's record lacked documentation of showering. In the email correspondence dated April 2, 2024, Licensed Assisted Living Director (LALD)-Q stated that there was no shower documentation available, as they did not have a system in place for unlicensed caregivers to mark whether they performed the shower or if the resident refused it. On April 9, 2024, at 4:05 p.m., Director of Nursing (DON)-A stated that the unlicensed caregivers were supposed to inform the nurse if the resident refused the shower, but she was unsure whether this was done for R1. DON-A also said that she could not locate any documentation related to the shower or refusal of shower for R1. The licensee's dated August, 2021 Resident Records Documentation policy indicated each resident's record would include documentation that services were provided as identified on the service plan. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 3 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to assess one of one resident (R1) for change of condition related to mobility, as well as failed to implement interventions to prevent skin breakdown. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01620		

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01620	Continued From page 4 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee's facility on March 11, 2022. R1's diagnoses included muscle weakness and difficulty walking. R1's assessment dated May 1, 2023, indicated R1 was able to transfer, eat, use the toilet, perform oral care, dress, and move independently. The assessment also noted bruises and dry skin for skin evaluation, as well as a risk for skin issues due to incontinence, decreased mobility, and a decrease in subcutaneous fat. R1's service plan dated May 2, 2023, indicated R1 was to receive assistance from one person with oral hygiene, toileting/peri-care, showering once per week, transfers, and medication management. R1's Kardex record, undated, indicated that R1 was incontinent and managed both independently and by staff. It also indicated bathing assistance once per week on Tuesday mornings. R1's physical therapy treatment encounter notes dated July 5, 2023, indicated R1 had new knee braces and the physical therapist assistant (PTA)-G educated R1 on putting it on. R1's physical therapy treatment encounter notes dated September 27, 2023, indicated PTA-G found bowel on R1's foot/leg. R1's physical therapy treatment encounter notes dated September 29, 2023, indicated R1 still had	01620		

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01620	Continued From page 5 bowel on his foot and legs. PTA-G updated concerns with unlicensed caregivers on her concerns. R1's physical therapy treatment encounter notes dated October 4, 2023, indicated R1 a significant decline in mobility as R1 was unable to ambulate more than a few steps at a time. R1 also required skilled assessment during therapy sessions to ensure safe mobility. R1's physical therapy treatment encounter notes dated October 18, 2023, indicated R1 needed help standing and pulling up pants. R1's physical therapy treatment encounter notes dated October 23, 2023, indicated R1 was unable to stand up and experienced a significant decline. R1's physical therapy treatment encounter notes dated October 25, 2023, indicated R1 were now one to two persons for transfers and needed help with toileting, getting dressed. R1 was close to needing EZ stand. R1's physical therapy treatment encounter notes dated October 30, 2023, indicated R1 was found in recliner and smelled soiled. R1's pant was half on. R1 needed assisted of two persons with EZ stand. R1's physical therapy treatment encounter notes dated October 31, 2023, indicated R1 was found soiled with bowel movement and urine in his recliner. R1 was not able to stand. Hoyer was recommended. R1's physical therapy treatment encounter notes dated November 6, 2023, indicated R1 was unable to straighten right lower extremity. R1	01620		

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01620	Continued From page 6 rated pain 7-9/10 with straightening. R1's physical therapy treatment encounter notes dated November 8, 2023, indicated R1 was weak and soiled. R1 was unable to stand and needed three to four caregivers to assist to the shower. During shower, a wound was found on the back of right knee. R1's hospital record dated November 9, 2023, at 3:04 p.m., indicated R1 was admitted to the hospital emergency department (ED) with right posterior knee wound of unknow duration. The wound was 3.9 centimeter (cm) in length by 3 cm in width by 0.5 cm in depth. The wound base was light pink, granular with 30% slough. R1's record lacked documentation of assessments by the nurse when he began wearing a brace and when he transitioned from two-person assistance to eventually using an EZ stand for transfers. R1's progress notes from July 18, 2023, to November 6, 2023, did not mention anything related to R1 wearing braces or refusing showers. R1's progress note dated November 8, 2023, at 3:52 p.m., documented by Director of Nursing (DON)-A, indicated R1 purchased and applied the knee braces on his own without a doctor's order. R1 refused to have the braces removed because they made him feel better. R1 wore them continually, which caused a large wound inside of the right knee. The wound was discovered on this date because R1 soiled himself and required a bath. On April 2, 2024, at 1:28 p.m., family member (FM)-B stated on the day of the incident, she said	01620		

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01620	Continued From page 7 she was visiting R1 and discovering him unresponsive in his recliner chair. R1 was soiled, and it required the effort of three to four staff members to remove his clothes and transport him to the whirlpool bath. It was during this bath that they first saw the wound. She said she knew R1 had been wearing a brace, as it helped to decrease muscle spasms and pain. On April 9, 2024, at 12:36 p.m., registered nurse (RN)-C stated she was aware of the brace; she had heard about it but had not physically seen it in person. She knew R1 had purchased the brace himself and applied it on his own terms. (RN)-C also said R1 was incontinent, and unlicensed caregivers were expected to check on him at least every shift or whenever he used the call light. She did not remember if unlicensed caregivers had reported to her about the resident refusing showers or care. (RN)-C said that skin assessments were typically conducted during quarterly assessments by the nurse or when the resident had a shower, during which unlicensed caregivers would check the resident's skin and report any issues. She said unlicensed caregivers should notify the nursing team if the resident refused a shower. On April 4, 2024, at 12:01 p.m., PTA-G as R1's mobility gradually declined, causing him to quit walking due to pain, she suggested he try knee braces. R1 purchased them independently four months prior, and she ensured he understood how to properly wear and remove them. PTA-G educated him on not wearing them constantly. She observed him putting on and taking off the braces and noted that the resident found relief from pain while wearing them. She recalled discussing the braces with the nursing staff but could not recall the specific staff member. PTA-G	01620		

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01620	Continued From page 8 said a month before the incident, the resident's mobility significantly declined, and he could no longer be able to stand. PTA-G told the unlicensed caregivers of this decline to prevent staff injury during care. She said the resident complained to her about using the call light without response from staff. She frequently observed he was soiled and had bowel movements on his shoes and clothes. She was not certain if he refused to be cleaned up or if staff neglected to assist him. On her last day working with him, he was very solid, requiring three to four people to assist him into a wheelchair and the bath. When they removed his braces, they discovered the wound, to which the resident seemed unaware. On April 4, 2024, at 10:40 a.m., unlicensed personnel (ULP)-N stated R1 used to walk and often sat in his recliner. She was not sure if he wore braces or not. She said sometimes R1 had bowel movements and attempted to conceal them. If she administered medication and detected an odor, she would then proceed to clean him up. On April 4, 2024, at 2:34 p.m., ULP-I stated she worked mostly the morning shifts and never assisted the resident with dressing. She said she knew about the brace, and R1 managed it independently. However, ULP-I was uncertain whether the nurses were aware of the brace or not. She stated R1 always dressed himself and that the night shift reported he refused care, although he did not refuse for her. On the day R1 was taken to the hospital, the night shift had not changed him, and it required assistance from multiple people to get him up as he could not stand. That week, she found him wet and soiled on several occasions. ULP-I confirmed seeing	01620		

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01620	Continued From page 9 R1's brace only once because staff members were not the ones who put the brace on. On April 4, 2024, at 12:31 p.m., licensed practical nurse (LPN)-R stated she did not recall whether R1 had a brace or not. She said R1 never refused care when she was on duty. LPN-R said she often found R1 soiled and would help him clean up. She said the call lights frequently went unanswered or took a long time. LPN-R confirmed no unlicensed caregivers informed her when R1 refused care and stated unlicensed caregivers were expected to inform the nurse or document it if the resident refused care. If R1 refused a shower, LPN-R said that unlicensed caregivers should at least assist him with bed baths, freshen him up, and provide him with clean clothes. On April 9, 2024, at 4:05 p.m., Director of Nursing (DON)-A stated she found out about the brace when they discovered the wound. She had not been aware of the brace before that time. She said she was informed by physical therapist later that R1 had purchased the brace online himself. The unlicensed caregivers did not report the presence of the brace to her, and she was uncertain whether they had reported it to another nurse. She confirmed the unlicensed caregivers did not inform the nurses about the resident's refusal of the shower. She said she was unable to locate any documentation regarding the shower or the resident's refusal of it. She also said the facility did not conduct skin assessments unless alerted by staff members of a problem. Otherwise, they conducted quarterly general assessments, which R1 had one six months prior. She acknowledged being aware of the resident's declining health. However, she stated the nurse responsible for his care should have conducted	01620		

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01620	Continued From page 10 the change of condition assessment when his care needs transitioned from one person's assistance to two and then to an EZ stand (stand assist lift). The licensee's dated August, 2023 Assessments, Reviews, and Monitoring indicated ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident. TIME PERIOD TO CORRECT: Seven (7) days.	01620		
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: The facility failed to ensure two of two residents reviewed (R1 and R2) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred. Regarding HL202579486M and R1 the facility was responsible for the maltreatment, which occurred at the facility. Please refer to the public maltreatment report for details. Regarding HL202572344M and R2 an individual was responsible for the maltreatment, in connection with incidents which occurred at the	02360	No plan of correction is required for this tag.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02360	Continued From page 11 facility. Please refer to the public maltreatment report for details.	02360		