Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL207125081M
Compliance #: HL207126821C

Date Concluded: October 14, 2024

Name, Address, and County of Licensee Investigated:
Maplewood Assisted Living
1890 Sherren Avenue
Maplewood, MN 55109
Ramsey County

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

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Inconclusive

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), facility staff, financially exploited the resident when she linked the resident's debit card and credit card to the AP's personal online Amazon account.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was inconclusive. The AP managed the resident's finances and assisted the resident with obtaining supplies. However, it could not be determined if unauthorized charges were made by the AP using the resident finances.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and family. The investigation included review of the resident record, the facility internal investigation, facility

incident reports, personnel files, financial records, and related facility policy and procedures. Also, the investigator observed resident interactions with staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included mild cognitive impairment and schizoaffective disorder. The resident's assessment indicated the resident struggled with mild to moderate dementia and did not have the reasoning to manage finances.

The facility internal investigation indicated the AP had possession of two of the resident's debit cards for approximately seven months. One debit card was used by an external homecare agency's staff when they took the resident on outings. The AP believed this card was eventually lost during an outing. The other card was kept in the AP's office and used by the AP to order the resident's supplies. The AP linked the debit card to her own online Amazon account after the resident was unable to access her own account. The AP managed the resident's finances without notifying facility leadership or making a significant attempt to obtain an appropriate representative payee for the resident.

The resident said she gave her debit card to the AP as part of the AP's job duties. The resident expressed confusion about how many cards she had and whether they were debit or credit cards. The resident also said she had no way to monitor her debit card activity of if purchases were made without her knowledge. The resident said she simply received whatever came in the mail.

The resident's bank statement indicated two Amazon purchases were made while the AP was still employed with the facility. One Amazon Prime purchase was made after the AP's employment was terminated, as well as numerous Uber and Walmart purchases. A police report was requested but not received, as the police investigation was open and ongoing. However, when consulted, a police officer involved with the case said the department was currently investigating the questionable charges found on the resident's bank statement.

When interviewed, a supervisor said the arrangement with the resident's debit card was discovered when the AP trained in a new staff member and informed her that managing the resident's debit card was one of their duties. The new staff member was uncomfortable with this and reported it to management. Staff assessed the resident and determined, due to her cognitive status, she was unable to knowingly enter such an arrangement with a staff member to manage her finances. The AP never provided the Amazon records to enable leadership to reconcile the Amazon records with the resident's bank records. The AP never provided leadership or the resident with receipts for any purchases, and she maintained she had done nothing wrong.

When interviewed, a supervisor said the AP admitted to taking possession of the resident's debit card to make purchases on her behalf. The AP did not provide receipts, so leadership was unable to verify if the purchases noted on the resident's bank statement were legitimate. The

supervisor stated it appeared there were many fraudulent purchases made with the resident's debit card. However, many of the purchases were made after the AP no longer worked for the facility. There was concern about caregivers from the resident's home care agency misusing her debit card, and facility leadership notified the home care agency to have them follow-up with their staff.

When interviewed, the AP said the resident began to have more trouble managing her finances and asked for help. The AP said she helped the resident cancel some ongoing subscriptions, and then began to place orders on behalf of the resident. The AP kept the resident's debit card locked in her office and placed orders as requested. The AP said she linked the resident's debit card to the AP's Amazon account because the resident lost access to her own Amazon account, and eventually lost her phone as well. The AP said the resident had also ordered an expensive engagement ring and the AP returned it for her. The AP said in hindsight she would have provided receipts to the resident for the purchases the AP made with the resident's debit card.

When interviewed, the resident said she had a debit card that she gave to a staff member to buy her groceries. The resident did not remember who the staff member was or what her role was at the facility. The resident did not recall purchasing a ring.

When consulted, a family member said he was pleased with how the facility managed the situation and had no concerns about the quality of care the resident received there.

In conclusion, the Minnesota Department of Health determined financial exploitation was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation and retrained staff regarding resident rights and finances. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was found to be in 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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Maplewood Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20712	A. BUILDING: _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD ASSISTED LIVING	1890 SHERREN AVENUE EAST MAPLEWOOD, MN 55109

(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: #HL207126821C/#HL207125081M On September 11, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 54 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL207126821C/#HL207125081M, tag identification 0590.	0 000		
0 590 SS=D	144G.42 Subd. 3 Facility restrictions (a) This subdivision does not apply to licensees that are Minnesota counties or other units of government. (b) A facility or staff person may not: (1) accept a power-of-attorney from residents for	0 590		

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0 590	Continued From page 1 any purpose, and may not accept appointments as guardians or conservators of residents; or (2) borrow a resident's funds or personal or real property, nor in any way convert a resident's property to the possession of the facility or staff person. (c) A facility may not serve as a resident's legal, designated, or other representative. (d) Nothing in this subdivision precludes a facility or staff person from accepting gifts of minimal value or precludes acceptance of donations or bequests made to a facility that are exempt from section 501(c)(3) of the Internal Revenue Code. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff did not act as the resident's financial designee/representative payee (rep payee) for one of one resident (R1) reviewed. The facility registered nurse (RN)-B, acted as R1's rep payee and had control over R1's finances. 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). Findings include: R1 was admitted September 19, 2019, with diagnoses that included mild cognitive impairment and schizoaffective disorder.	0 590	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.	

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0 590	Continued From page 2 R1's service plan dated August 7, 2024, indicated R1 received services for medication management, help with activities of daily living, safety checks, and behavioral support. R1's Individual Abuse Prevention Plan dated July 27, 2024, indicated R1 was not able to manage her finances independently. During interview on September 11, 2024, at 10:45 a.m., R1 stated she gave her debit card to a staff member she trusted, to purchase personal care items on her behalf. R1's could not remember who the staff member was or what the staff member's role was at the facility. During an interview on September 13, 2024, at 12:42 p.m., RN-B stated she had R1's debit card after R1 asked her for help with making purchases. RN-B linked R1's debit card to RN-B's online Amazon account because R1 had lost both her phone and access to her own Amazon account. RN-B stated she made online purchases for R1's personal care items via RN-B's personal Amazon account. During an interview on September 18, 2024, at 10:10 a.m., RN-A said RN-B did not provide the resident or facility leadership with receipts or other financial documentation with which to reconcile RN-B's purchases with R1's banking statements. The facility had initiated the process to secure an appropriate rep payee for R1. R1's most recent bank statement indicated two Amazon purchases were made while the AP was still employed with the facility. No receipts were available to verify the purchases. A resident financial policy was requested but not	0 590	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.	

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0 590	Continued From page 3 received. An undated staff training document, titled "Financial Exploitation, Misappropriation of Resident Property, and Timely Reporting-Staff Education," indicated it was the facility's policy that staff should not withhold, store, or maintain a resident's financial resources such as cash, credit, or debit cards. No further information was provided. TIME PERIOD OF CORRECTION: Twenty-one (21) days.	0 590		