DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL221391662M **Date Concluded:** February 20, 2023
Compliance #: HL221393235C

Name, Address, and County of Licensee Investigated:
The Terraces Assisted Living
901 Feltl Court
Hopkins, MN, 55343
Hennepin County

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

Evaluator's Name: Danyell Eccleston, 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 two residents when she stole a bank card from each resident and used the cards to make unauthorized purchases at several different stores.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP stole two bank cards from separate residents and used the cards to make unauthorized purchases. The first resident's card was used to make unauthorized transactions totaling over $500.00, and the second resident's card was used to make unauthorized transactions totaling over $1,500.00.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the county

attorney's office. The investigation included review of employee records, medical records, facility policies and procedures, law enforcement records.

The residents resided in an assisted living facility. The first resident's diagnoses included high blood pressure and his service plan included assistance with safety checks, laundry, and weekly housekeeping. The second resident's diagnoses included osteoporosis and high blood pressure and her service plan included assistance with laundry and weekly housekeeping.

Review of the AP's employment file indicated she was hired as a housekeeper and completed cleaning and resident laundry tasks. The AP's employee file indicated the AP completed education about resident bill of rights and the vulnerable adult statute. The AP's initial background study indicated more time was needed for completion and no supervision of the AP was needed, however, approximately two months later, the AP's background study indicated the AP was disqualified to provide direct care and indicated she posed a risk of harm. Review of housekeeping documentation indicated the AP worked at the facility during the timeframe in question.

Review of Law enforcement video footage, photographs, and receipts from stores where both residents bank cards were used without authorization indicated the AP was the person making the unauthorized charges on both resident's bank cards.

Review of a law enforcement report indicated the first resident's bank card had fraudulent charges totaling over $500.00. The officer interviewed employees from multiple stores, reviewed surveillance footage, received store receipts, and obtained bank records which indicated the AP as the individual that made the unauthorized transactions.
The officer contacted the AP via phone, and she initially denied making any transactions with the first resident's card but later admitted to making some of the fraudulent transactions. Criminal charges were filed with the district court against the AP.

Review of an additional law enforcement report indicated the second resident's bank card had fraudulent charges totaling over $1,500.00. The report indicated the phone number previously listed for the AP was no longer in service. The report indicated the officer interviewed employees from multiple stores, reviewed surveillance footage, received store receipts, and obtained bank records which indicated the AP was the individual who made the unauthorized transactions. Criminal charges were filed with the district court against the AP.

During an interview, a member of facility leadership stated housekeeping staff took the resident's laundry to and from the laundry room and they check the residents clothing pockets prior to laundering clothing. The AP worked on the floor where the first resident resided, and the AP worked the day the resident reported losing his bank card.

During an interview, a second leadership member stated a family member of the first resident made her aware unauthorized purchases were made on the resident's bank card and the

resident believed he left his card and forty dollars in cash in a pants pocket after using the vending machine. The pants were put in the laundry and both the cash and card were missing. The AP denied finding the first resident's cash or bank card. The family member of the second resident reported items from the second resident's purse, including a bank card, were missing and fraudulent charges were made using the residents missing bank card. The leadership staff stated the resident was in a transitional care center when her family reported the residents bank card was missing. The AP was assigned to that's residents' room and documented washing the second resident's sheets during the time in question.

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 Adults interviewed: Yes
Families interviewed: Yes
Alleged Perpetrator interviewed: No, the AP did not respond to attempts for interview

Action taken by facility:
The facility conducted internal investigations. The AP is no longer employed at the facility.

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
Hopkins City Attorney
Hopkins Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22139	A. BUILDING: ______ B. WING ______	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES ASSISTED LIVING	901 FELTL COURT HOPKINS, MN 55343

(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 LICENSING 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: HL221393235C/ HL221391662M On January 12, 2023, 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 77 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL221393235C/ #HL221391662M, tag identification 2360.	0 000	The Minnesota Department of Health documents the State Licensing 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

Minnesota Department of Health

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

Minnesota Department of Health

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02360	Continued From page 1 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 2 of 2 residents reviewed (R1, R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	