Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL235906244M
Compliance #: HL235901925C

Date Concluded: September 6, 2023

Name, Address, and County of Licensee Investigated:
Home Instead Senior Care
4445 West 77th Street
Edina, MN 55435
Hennepin County

Facility Type: Home Care Provider

Evaluator's Name: Willette Shafer, 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 a client when the AP stole checks from the client's check book and attempted to cash a check for $9,450.25.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP admitted to taking the client's check without their knowledge and attempting to cash a forged check for $9,450.25.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator contacted the client's family and law enforcement. The investigation included review of medical records, personnel files, facility policies, internal investigation, and law enforcement report.

The client resided in a transitional care senior apartment and received separate comprehensive home care services. The client's diagnoses included Parkinson's disease and a recent hip fracture. The client's service plan included assistance with grooming, toileting, transfers, meals, and housekeeping. The client's assessment indicated the client was alert and oriented.

According to the law enforcement report, the client's financial institution noticed a suspicious check and contacted the family. A check for $9450 was written to a payee the family did not recognize. Law enforcement compared handwriting from the check to an employee sign-in sheet and found a match. Law enforcement confronted the AP and the AP admitted to taking the client's check, forging the information on the check, and attempted to cash it at an ATM. The AP was arrested. In addition, there for four additional checks missing from the resident's checkbooks and stop payments by the bank were issued.

During an interview, the client's family member stated the client's financial intuition called and reported a suspicious check written against the client's account. The family member consulted with several family members and stopped payment on the check. Law enforcement was contacted, and the incident was reported to the facility the resident resided and the home care agency. The family member said law enforcement identified a suspect based on staffing logs and the handwriting on the check. The family member stated law enforcement met with the AP and the AP admitted he stole a blank check, forged information, and attempted to cash it.

During an interview, law enforcement stated they received a complaint of suspected financial exploitation. Law enforcement identified an AP based on a handwriting comparison. The AP admitted he took the client's check from his apartment, wrote the check out for a large amount, and attempted to cash the check at an ATM. Law enforcement obtained video footage of the AP, which showed the AP trying to cash the check at an ATM. The AP was charged with check forgery.

During an interview, a member of management stated the agency was notified of the incident from the client's family member. The agency spoke with law enforcement and learned the AP admitted he tried to cash a check he wrote from the client and the AP was arrested. The AP completed vulnerable adult maltreatment training upon hire. An internal investigation was completed, and the AP no longer works for the agency.

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;
(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

Vulnerable Adult interviewed: No, family declined stated it would be upsetting to client.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, AP declined the interview. AP stated he admitted he stole the check and attempted to cash it to the police.

Action taken by facility:
The agency conducted an internal investigation. The AP no longer works for the agency.

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
Edina City Attorney
Edina Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H23590	A. BUILDING: _____ B. WING _____	C 07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME INSTEAD SENIOR CARE	4445 WEST 77TH STREET #121 EDINA, MN 55435

(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 CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, 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: #HL235901925C/#HL235906244M On July 25, 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 62 clients receiving services under the provider's Comprehensive license. The following correction order is issued for #HL235901925C/#HL235906244M, tag identification 0325.	0 000	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 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 surveyors' 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. 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 144A.474 SUBDIVISION 11 (b)(1)(2).	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment be free from physical and verbal abuse, neglect,	0 325		

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0 325	Continued From page 1 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: The facility failed to ensure one of one client reviewed (C1) was free from maltreatment. Findings include: 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.	0 325	No plan of correction is required for this tag.	