Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL25952005M
Compliance #: HL25952005C

Date Concluded: February 12, 2020

Name, Address, and County of Licensee Investigated:
Avinity Home Care
7645 Lyndale Avenue South
Richfield, MN 55423
Hennepin County

Name, Address, and County of Housing with Services location:
Golden Oaks, Proctor
23 Westview Dr.
Proctor, MN 55810
Saint Louis County

Facility Type: Home Care Provider

Investigator's Name:
Kathie Siemsen, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:
An investigator from 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.

Allegation(s):
It is alleged: The alleged perpetrator (AP) financially exploited the client when the AP received money from the client for private services.

Investigative Findings and Conclusion:
Financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP, a facility staff member, offered a plan for the client to move out of the facility and provide services in his home to the client instead. The AP received money from the client for advanced payment for room, board, special diet and services. The client did not move out of the facility, did not receive services from the AP and the money was not returned to the client.

The investigation included interviews with facility staff, including administrative staff, nursing staff, unlicensed staff and the client. In addition, the investigator contacted law enforcement.

The investigation included a review of policies and procedures related to financial exploitation. The investigator reviewed medical records, financial records and personnel records.

Review of the medical record indicated the client's diagnoses included stroke with right side paralysis. The client's service plan included assistance with dressing, grooming bathing and medications. The client was alert, orientated and able to make his needs known. The client needed assistance with finances.

The client's case manager received a telephone call from the facility informing the case manager the client had given his notice to move out of the facility. During a care conference later that week the client reported he planned to move into a private home of a current facility employee. The client named the AP. During the care conference the office manager reported the client was four months behind on his monthly bills to the facility, totaling approximately $800.00. The case manager asked the client if he and the AP exchanged any money. The client stated he gave the AP around $800.00 but could not remember for certain. The facility placed the AP on administrative leave and notified the police.

A few days later, a woman introduced to staff as the client's granddaughter picked up the client for an outing. The administrator then received a telephone call from the corporate office (approximately 145 miles away) stating the client was there with a woman. At the corporate office, the client stated the AP and the AP's spouse said they could provide care for him, it was his idea and he did not want the AP to get into trouble. After the meeting, the corporate office staff observed the client and the woman get into a car driven by the AP. It was identified the woman was not the client's granddaughter and suspected to be the AP's friend.

During an interview the administrator stated initially, the client reported to the office manager he was going to move in with the AP but wanted it to be a secret. The facility called the AP and the AP denied taking any money from the client or that the client could move into his private residence. The administrator stated the client stated he did not want the AP to get into any trouble. The facility recommended the client not move in with the AP. The administrator stated the facility does not provide assistance with running errands or handling the client's money.

During an interview, the client stated he did gave the AP $800 or $850 as part of his rent to move in with the AP. The client stated the AP drove him to the bank to withdraw the cash all at once. The client stated he also occasionally paid the AP gas money to drive him to the store. The client and the AP got to know each other because the AP was appointed to take the client outside to smoke and began a friendship. The client had not talked to the AP since the AP had stopped working for the facility. The AP would take the client to the bank because the client did not have a checking account. The client stated the AP did not give the money back.

The facility place the AP on administrative leave during an investigation. The facility interviewed staff and residents. Staff, including the AP were provided training on no acceptance of gifts or money upon hire and yearly. The administrator stated all staff sign the policy at each review

and had all current staff review the policy again after the incident. The AP was no longer employed by the facility.

The investigator attempted to contact the AP. The AP failed to respond to the subpoena.

In conclusion, financial exploitation was substantiated.

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 Adult interviewed: Yes.
Family/Responsible Party interviewed: No, the client is his own responsible party.
Alleged Perpetrator interviewed: No, attempted to contact the AP. The AP failed to respond to the subpoena.

Action taken by facility:
The facility place the AP on administrative leave during an investigation. The facility interviewed staff and residents. Staff, including the AP were provided training on no acceptance of gifts or money upon hire and yearly. The facility re-trained all staff on the facility's Ethics and Conflict of Interest policy. The AP was no longer employed by 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.

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:

Health Regulation Division – Home Care and Assisted Living Program
The Office of Ombudsman for Long-Term Care
Saint Louis County Attorney
Proctor City Attorney
Proctor Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H25952	A. BUILDING: _____ B. WING _____	C 01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN OAKS ADV ASSIST LIVING	23 WATERVIEW DRIVE PROCTOR, MN 55810

(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, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. 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: On January 15, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL25952006C/#HL25952005M. At the time of the survey, there were 20 clients receiving services under the comprehensive license. The following correction order is issued for #HL25952006C/#HL25952005M, tag identification 0325.	0 000		
0 325	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;	0 325		

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0 325	Continued From page 1 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 was financial exploited. Findings include: On February 12, 2020 , the Minnesota Department of Health (MDH) issued a determination financial exploitation occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No plan of correction is required. Please refer to the public maltreatment report for details.	