Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL265055143M
Compliance #: HL265058857C

Date Concluded: October 18, 2023

Name, Address, and County of Licensee Investigated:
Synergy Home Care Minneapolis
7575 Golden Valley Road #378
Golden Valley, MN 55427
Hennepin County

Facility Type: Home Care Provider

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Financial Exploitation: Substantiated, individual responsibility
Neglect: Inconclusive

Nature of Visit:
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 the client's ATM card and credit card, charging over $2000 for personal use.

The facility neglected the client when they did not ensure staff changed the client's soiled incontinent brief for 7 hours, which made the client feel humiliated and caused the client to miss a therapy appointment.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The facility received a cleared background check on the AP and provided the AP with appropriate training and supervision. The AP worked with the client seven times before stealing her cash card and credit card for personal use. Surveillance video showed the AP and accomplices use the cards at multiple retail stores charging $2,609.76.

The allegation of neglect in inconclusive, due to conflicting information. The client reported staff did not respond to her home to assist her with as needed incontinence care. The facility schedule indicated they sent a staff to the client's home and paid her for 1.5 hours so she could provide incontinence care. The staff did not respond to requests for an interview.

The investigator conducted interviews with administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and a family member. The investigation included review of the AP's personnel file, facility policies, and procedures related to maltreatment of vulnerable adults, boundaries, job description, and do's and don'ts of working with home care clients.

The client received comprehensive home care services in their home. The client's diagnoses included cerebral palsy. The client received scheduled cares in the morning and at bedtime. The client's service plan included assistance with, bathing, grooming, dressing, hygiene, incontinence care, transfers, catheter care, and housekeeping. The client's assessment indicated the client was independent once staff completed the clients cares and transferred her to her power wheelchair.

A law enforcement report indicated the resident's bank contacted the client due to unusual activity on her card. The law enforcement investigation indicated six transactions at six different stores at a local mall. Surveillance video obtained from the mall and several of the stores showed the AP and three accomplices using the client's cards to make purchases.

During an interview, a family member stated the AP had been in the client's home and had access to her purse, which contained the client's credit and bank cards.

During an interview, an administrative staff stated the licensee trained the AP, and determined her competency working with the client, as well as face to face supervision by their registered nurse. The administrative staff stated there were no red flags with the AP.

During an interview, the client stated she had been a victim of similar theft in the past and felt guilty that she did not lock up all her belongings before the AP came to her home. The client stated she had recently been the victim of a break-in, and she feared it was possibly the AP or the AP's accomplices.

During an interview a law enforcement officer indicated they would be charging the AP for theft, but charges were pending at the time of the MDH investigation.

During an interview, the AP denied the allegation.

The client also spoke of an incident where she called the facility to send a staff for unscheduled incontinence care on a specific date. The client stated no one ever came until the scheduled night staff.

The facility records indicated one day they assigned the AP, who submitted paperwork she had completed unscheduled incontinence cares, but the dates did not match.

In conclusion, financial exploitation is substantiated, and neglect is inconclusive.

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.

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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The AP no longer works for 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:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Hennepin County Attorney

Golden Valley City Attorney

Golden valley Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H26505	A. BUILDING: _____ B. WING _____	C 09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYNERGY HOME CARE MINNEAPOLIS	7575 GOLDEN VALLEY RD #378 GOLDEN VALLEY, MN 55427

(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 HOME CARE PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order is 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: #HL265058857C/#HL265055143M On September 13, 2023, 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 65 clients receiving services under the provider's Comprehensive license. The following correction order is issued for #HL265058857C/#HL265055143M, tag identification 0325.	0 000		
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment 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 This MN Requirement is not met as evidenced by:	0 325		

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0 325	Continued From page 1 The facility failed to ensure one of one clients 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.	