Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL290041206M
Compliance #: HL290042013C

Date Concluded: December 22, 2022

Name, Address, and County of Licensee Investigated:
The Shores of Lake Phalen
1870 East Shore Drive
Maplewood, MN 55109
Ramsey County

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

Evaluator's Name: Brandon Martfeld, RN
Special Investigator

Finding: Substantiated, individual responsibility

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 the resident when a check was written to the AP for $25,000 dollars.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP wrote a check out to herself and forged the resident's spouse's signature. The AP cashed the check in the amount of $25,000 dollars.

The investigator conducted interviews with administrative staff and nursing staff. The investigator contacted the resident's family member and law enforcement. The AP did not respond to a subpoena for an interview. The investigation included review of medical records, facility grievances, law enforcement records, photo image of the check written to AP, images of resident and resident's spouse's signatures, AP's personnel file, and facility policies that

included assessments, complaint/grievances, employee orientation, employee record, individual abuse prevention plan, vulnerable adult, and vulnerable adult education.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with showers, dressing, grooming, hourly safety checks, laundry, medication administration, toileting, and stand by assist with walking. The resident's assessment indicated resident was not oriented. The resident's vulnerability assessment indicated the resident had difficulty hearing and did not manage his own finances. The executive director was to be made aware of any suspicion of financial abuse or exploitation.

The facility's grievance record indicated leadership was notified of the resident's checkbook missing from the apartment. The grievance record indicated a check was wrote to the AP for $25,000 dollars and cashed by the AP five days later.

A photo image of the check indicated it was made out to the AP in the amount of $25,000 dollars. The image of the check provided dates that showed the AP made a mobile deposit five days later.

Review of a signature card showed the resident's and resident's spouse's signature. The check's signature did not match either the resident or the resident's spouse's signatures.

During an interview, the resident's family member stated they reviewed the resident's bank account and saw a check that cleared for $25,000 dollars. The family member looked at the check image, and saw a check written to the AP. The signature on the check had a fake signature of the resident's spouse. The family member stated the resident's spouse's signature includes first name, middle initial and last name, however the check included first name, and part of the last name, and the penmanship did not match.

During an interview, leadership stated the family member notified leadership that $25,000 dollars was missing from the resident's bank account. Leadership stated law enforcement was involved, and the AP was suspended from work. After a couple months, law enforcement notified leadership of the AP admitted to stealing $25,000 dollars from the resident. The AP was no longer employed by the facility.

During an interview, law enforcement stated the AP denied taking the money at first, then paused and stated the check was a gift. The AP stated the money was spent on various bills and car parts. Law enforcement stated the resident told them he did not give the AP $25,000 dollars as a gift.

The facility's employee handbook indicated on page 9, resident belongings are not to be taken from the rooms by any employee; items are not to be borrowed or received as a gift. On page 10, the employee handbook indicated all employees must have a clear understanding of the

importance of not becoming involved with exploitation or misappropriation of resident property by resident. The same handbook on page 10, further indicated misappropriation is defined as the intentional, illegal use of the property or funds of another person for one's own use.

The AP's personnel file record included a signed acknowledgement by the AP indicating reading, understanding, and adhering to the policies outlined in the employee handbook.

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;

Vulnerable Adult interviewed: No. Unable due to the resident's cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, attempted but did not reach.

Action taken by facility:
Leadership placed the AP on suspension and spoke with law enforcement. Leadership provided vulnerable adult education to staff. The AP was 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

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
Ramsey County Attorney
Maplewood City Attorney
Maplewood Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29004	A. BUILDING: _____ B. WING _____	C 10/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHORES OF LAKE PHALEN	1870 EAST SHORE DRIVE 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 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: #HL290042013C / HL290041206M On October 17, 2022, 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 73 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL290042013C / HL290041206M, tag identification 0630, 2360 and 2480.	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.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement an individual abuse prevention plan (IAPP) that included an individualized review or assessment of the person's susceptibility to abuse by another individual for one of one resident (R1). 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) 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's diagnoses included dementia. R1's service plan dated July 19, 2021, indicated R1 required assistance with showering, dressing, grooming, toileting, safety checks, laundry, medication administration and stand by assist with walking using a walker.	0 630		

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0 630	Continued From page 2 R1's assessment dated July 9, 2021, indicated R1 was alert and orietated. R1's IAPP dated July 9, 2021, indicated R1 was vulnerable to managing personal finances. R1's intervention indicated licensed assisted living director (LALD) was to be updated with any signs or symptoms of financial abuse or exploitation. The licensee complaint and grievance record dated May 19, 2022, indicated R1's family member reported R1's checkbook was missing from the apartment. The family member reported a check was written out to unlicensed personnel (ULP)-E for 25,000 dollars on May 6, 2022 and cashed on May 11, 2022. R1's IAPP dated July 29, 2022, indicated R1 was vulnerable to managing personal finances. R1's intervention indicated R1's family member assisted and the LALD was to be updated with any signs or symptoms of financial abuse or exploitation. R1's IAPP failed to included new interventions to prevent financial exploitation and identify the incident of having his checkbook and money stolen. During an interview on November 8, 2022, at 12:07 p.m. the director of nursing (DON)-C stated the ULP-E admitted to law enforcement of taking the check. DON-C verified the IAPP from July 9, 2021, and July 29, 2022, had no changes. DON-C further stated following the incident, R1 should have had a new assessment completed and the interventions should be more tailored to the incident and the resident. The licensee IAPP policy dated August 1, 2021, indicated the plan would contain an individualized review or assessment of the person's	0 630		

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0 630	Continued From page 3 susceptibility to abuse by another individual. This included specific measures to be taken to minimize risk of abuse to that person or other vulnerable adults. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews, and document review, the licensee failed to ensure one of one resident reviewed (R1) was free from maltreatment. R1 was financially exploited. Findings include: The Minnesota Department of Health (MDH) issued a determination that financially exploitation occurred, and that an individual staff person was responsible for the maltreatment, in connection with incident which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	
02480 SS=F	144G.91 Subd. 20 Grievances and inquiries Residents have the right to make and receive a timely response to a complaint or inquiry, without limitation. Residents have the right to know and every facility must provide the name and contact information of the person representing the facility	02480		

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02480	Continued From page 4 who is designated to handle and resolve complaints and inquiries. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to investigate an allegation of financial exploitation that occurred to one of one resident (R1), to determine if financial explotation occurred to all other residents. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's medical record was reviewed. R1's diagnoses included dementia. R1's service plan dated July 19, 2021, indicated R1 required assistance with showering, dressing, grooming, toileting, safety checks, laundry, medication administration and stand by assist with walking using a walker. R1's assessment dated July 9, 2021, indicated R1 was alert and orientated. The licensee complaint and grievance record dated May 19, 2022, indicated R1's family member reported R1's checkbook was missing from the apartment. The family member reported a check was written out to unlicensed personnel (ULP)-E for 25,000 dollars on May 6, 2022, and cashed May 11, 2022.	02480		

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02480	Continued From page 5 During an interview on October 31, 2022, at 12:53 p.m. R1's family member (FM)-A stated she notified the local law enforcement and licensed assisted living director (LALD)-B. FM-A stated ULP-E denied taking the check at first to law enforcement, but then admitted to cashing the check. FM-A stated the licensee did not provide any follow up conversations regarding the incident. During an interview on November 2, 2022, at 8:48 a.m. LALD-B stated ULP-E was placed on suspension immediately after learning of the allegation. LALD-B stated interviews with other staff related to the allegation were not completed. During an interview on November 8, 2022, at 12:07 p.m. director of nursing (DON)-C stated no interviews were completed with other residents or staff regarding the allegation. During a follow up interview on November 8, 2022, at 1:24 p.m., LALD-B stated there was no internal investigation completed. The licensee Complaint/Grievance policy dated August 1, 2021, indicated an investigation surrounding the facts of the complaint shall be initiated if needed, after completion of the investigation a resolution communicated to the resident and/or resident representative. TIME PERIOD FOR CORRECTION: twenty one (21) days	02480		