Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL293521781M
Compliance #: HL293529487C

Date Concluded: July 30, 2024

Name, Address, and County of Licensee Investigated:
Traditions of La Crescent
333 South 2nd Street
La Crescent, MN 55947
Houston County

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

Evaluator's Name: Christine Bluhm, 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 the resident when she stole the resident's checks, wrote out the checks to herself and cashed the checks totaling $800.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP, an unlicensed caregiver, was responsible for the maltreatment. The AP admitted that she took the checks that belonged to the resident, and cashed the checks when police questioned her.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of the resident record, death record, facility internal investigation, facility incident reports, law enforcement reports, related facility policy and procedures.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's dementia and heart disease. The resident's service plan included assistance with all activities of daily living, medication management and hourly safety checks. The resident's assessment indicated he had impaired memory and decision-making ability, and family managed all finances for the resident.

The police report indicated the facility contacted law enforcement regarding an employee (the AP) who was suspected of stealing checks from a resident. The same document indicated the police interviewed the AP and the AP admitted she took two checks belonging to the resident from an office at the facility and cashed them. Police showed the AP copies of the forged checks, and the AP verified the checks were written by her. The AP told police that she knew it was going to come back at her and it was completely her fault.

During the investigation, copies of the forged checks were obtained from the police file for review. The two checks were made out to the AP, endorsed by the AP, and cashed in the amounts of $300 and $500 dollars.

During an interview, the facility's regional director stated per facility policy, staff are not allowed to handle or be involved with resident finances and there was no reason for the AP to have the checks in her possession. The director stated the AP had written out the checks to herself and endorsed them.

During interview, a family member stated the resident had dementia and was not capable of writing out checks or managing money. The family member thought the checks were moved in with the resident early on and remained in the office in his file throughout the time the resident lived at the facility. The family member stated that they have not received any of the stolen money back or any further communication from the facility regarding the incident.

The AP did not respond to multiple attempts for an interview.

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:
(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: No, the resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No. The AP did not return multiple requests for an interview.

Action taken by facility:
The facility contacted police when they were made aware of the check forgery. The AP was no longer employed by the facility.

Action taken by the Minnesota Department of Health:
<u>If substantiated and individual responsibility only, with no other correction orders besides the right to be free from maltreatment</u>:

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
Houston County Attorney
La Crescent City Attorney
La Crescent Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29352	A. BUILDING: _____ B. WING _____	C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF LA CRESCENT	333 2ND STREET SOUTH LA CRESCENT, MN 55947

(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 In accordance with Minnesota Statutes, sectio144G.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: HL293529487C/#HL293521781M On July 2, 2024 the Minnesota Department of Health initiated a complaint investigation at the above provider, and the following correction orders are issued. The following correction order is issued/orders are issued for #HL293529487C/#HL293521781M tag identification 2360.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State 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 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 evaluators' 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 144G.31 SUBDIVISION 1-3.	

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02360	Continued From page 1	02360		
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: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual 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	Please see the Public Maltreatment report for details.	