DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304961661M
Compliance #: HL304964727C

Date Concluded: September 24, 2024

Name, Address, and County of Licensee Investigated:
Lifecare Medical Center
201 10th Street SE
Roseau, MN 56751
Roseau County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, facility and 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 perpetrators, unlicensed personnel at the facility, financially exploited a resident when they accepted $226,750 from the resident. The resident's power of attorney (POA) was removed without the POA's knowledge and AP1 was appointed POA and written into the resident's will as the sole benefactor. After the resident passed away, the resident's family had no claim to the resident's estate and AP1 took possession of the resident's remaining assets. AP2 received $24,500 from the resident while she was an employee of the facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The facility and AP1 were responsible for the maltreatment. AP1 acquired funds and property from the resident while working for the facility, including over $175,000 from the resident and the resident's van. After the resident's death, AP1 sold the resident's van for at least $40,000.
The facility was made aware of concerns related to AP1 serving as the resident's power of attorney in 2022. The facility investigated the issue and interviewed AP1 and the resident. The

facility allowed AP1 to continue her employment since the resident had moved to another facility owned and operated by the licensee.

Financial exploitation against AP2 was not substantiated. Although AP2 received at least $24,500 from the resident, AP2 received the money after her employment at the facility ended.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the resident's case worker. The investigation included review of the resident's bank records, resident records, internal investigation documentation, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed care and services in the facility.

The resident resided in an assisted living facility with a diagnosis of multiple sclerosis. The resident's service plan included assistance with dressing, grooming, bathing, and medication administration. The resident's assessment indicated the resident was hard of hearing, had anxiety, and was dependent on staff for transfers. The resident's cognition was noted to have "other significant orientation concerns that require redirection...he does have intermittent confusion and disorientation. Staff redirect or call friends and he does better with this." The resident was noted to need occasional reassurance or redirection due to mild disorientation to person, place, or time. The assessment also indicated the "resident has progressing MS [multiple sclerosis]. He is being followed by home care, physical therapy, and occupational therapy. He has had an increase in confusion and intermittent disorientation. He becomes upset with these episodes. He will call friends and this will make him feel at ease. He is orientated after a short period of time and he knows he is having these episodes and this causes frustration for him as well."

The resident's medical record documentation including the service plan and assisted living agreement, identified AP1 was the resident's power of attorney and emergency contact. Medical record documentation also identified AP2 was an emergency contact/friend. Progress notes indicated AP1 was routinely updated on aspects of the resident's care and made decisions related to the resident's care. Progress notes referred to AP1 by her nickname and identified her as the power of attorney and referred to her as a friend/family of the resident. Court records indicated AP1 was named in the resident's Last Will and Testament as the sole benefactor of the resident's estate.

AP1's employee record indicated she began working at the facility in 2014 and was named the resident's power of attorney four years later.

Investigative documents included a letter written to the resident from the law office that assisted with appointing AP1 as the power of attorney. The letter indicated the law office had spoken with the resident's former power of attorney [a relative of the resident] and they had indicated "he was concerned about monies that may have already been paid to [AP1]…that was

in violation of the Employment Policies for [facility name] where [AP1] is employed. As you and I discussed on [date], [facility name] does have policies prohibiting residents from gifting or tipping employees and/or their families, and further, a policy preventing employees and/or their families from accepting gifts or tips from residents. I further understand that you have given some items to [AP1] or her family and those items were to be returned…"

Bank records over an approximately six-year period, indicated AP1, her husband, and children, accepted checks totaling $175,995 from the resident, and AP2 accepted checks totaling $24,500. During this time, the resident also withdrew $27,350 in cash. Checks written to AP1's husband totaled $57,200, and checks written to her children totaled $1,500.

Four years after AP1 was appointed power of attorney, the facility initiated an investigation after concerns were raised when the resident's personal items were taken from his assisted living apartment after he moved to the skilled nursing facility also operated by the licensee. The facility was made aware of allegations the resident's belongings and his van went missing after he discharged from the assisted living to a nursing home. The internal investigation indicated there "is history here with [AP1] becoming POA. Past director was involved and stated she was unable to be the POA. [the resident] involved lawyers and deemed that he was of sound mind and stated that [AP1] could be over his medical but not financial. [AP1] and her family cleaned out [the resident's] apartment. They threw what they didn't want and took the rest, including the van." The facility interviewed AP1 who confirmed she "threw a bunch away and gave the rest to other staff members."

The internal investigation indicated the facility was aware AP1 was in possession of the resident's van, that it was being stored at her house, and that the resident had a CD (savings account) in the bank for AP1's children "when he is gone." The investigation indicated the facility was aware AP1 was the resident's power of attorney and told the resident she had cancer. The facility was not able to verify AP1's claims of having cancer but noted AP1 did not have any medical leaves or extended time off. The investigation indicated the facility was told by the resident's family that "large sums of money were missing." The facility interviewed AP1 who denied having received any money beyond a few hundred dollars. The investigation indicated, "Through this interview it was very clear that the relationship between Him and [AP1] is a very special bond. They view each other as a Father/Daughter and he is Grandpa to her children. Both [the resident] and [AP1] report to have a true and genuine relationship. [The resident] stated that he has never felt coerced or persuaded into giving any gifts or money to any staff members at Oak Crest. When asked if he ever gifted money or belongings to a staff member at Oak Crest, He said it really doesn't matter because he can give money to whomever he wants. The investigation indicated that it was determined no other residents were affected by [AP1's] alleged actions. A legal consultation concerning [AP1's] employment was performed…We believe that the relationship between [AP1] and [the resident] is genuine and mutual. The incident with [AP1] and [the resident] seems to be an isolated incident. We feel that because [the resident] no longer resides at Oak Crest that this is no longer a conflict of interest. We don't feel that [AP1] is a threat or a risk to our residents at Oak Crest Senior

Housing. No time during the investigation did we find any evidence that [AP1] coerced or manipulated [the resident].” Staff met with AP1 and explained that “the boundaries she crossed as a care giver with a resident are not allowed and they cannot occur again. [AP1] understood and realizes this. [AP1] shared again that when [the resident] moved, he wanted to give her the van and turn it into her name. She told him no, that he couldn't do that. He also wanted to give her his money and she told him no and refused that too. She wanted us to know that [the resident] chose her and her family. He asked if he could be Grandpa to her kids. Him and his wife didn't have any children and he wanted to have them as his family…”

During an interview, AP1 stated she understood that as an employee she could not accept any gifts but "my situation with him was so different. Until he died, I was taking care of him, until his last breath. He called me a daughter because he wanted nothing to do with his family...He wanted to help me and my family, he wanted us to be a real family with him, he wanted to adopt us." AP1 stated she first met the resident when she worked at a clinic and the resident came in as a patient and she got to know him better when she was his caregiver at the assisted living facility. AP1 was asked if the resident had ever given her money and if so, how much. AP1 stated he had given her some money. AP1 was asked if the resident had ever written checks to her husband or other family members. AP1 confirmed she introduced her children and husband to the resident and they all became close with the resident. AP1 stated no, the resident had never written checks to her husband. AP1 was told the investigator had copies of checks the resident had written to her husband with some amounts above $10,000 and if her answer was truthful. AP1 stated that the resident had written checks to her husband occasionally and her kids got $500 checks for Christmas one year. AP1 stated the resident wanted to give his money to her and "you can ask everyone here; we were so connected. He'd come to my house; I'd go visit him every single day...we were so close." AP1 was asked if her relationship with the resident while he lived at the assisted living facility was a conflict of interest or if the facility had ever told her the relationship was a conflict of interest. AP1 stated the facility was well aware of her relationship with the resident and she was the emergency contact for the resident, so the facility called her with updates, and she had never been told it was a conflict of interest. AP1 was asked how much money the resident had given her, and she stated she wasn't sure. AP1 was asked if it was over $10,000 and she stated yes. AP1 was asked if it was over $50,000 and stated "Yes, it was a lot of money, but I don't know the exact amount." AP1 was told by the investigator that it appeared that at least $200,000 had been given to her and was asked if that was accurate. AP1 stated, "I feel like he was my dad, and I don't know, he just wanted to give it to us. He wanted to give it to me and my kids." AP1 stated the resident told her "It's my money, I can give it to who I want." AP1 confirmed she did not disclose the truth when interviewed by the facility in 2022 because the resident "didn't want anybody to know. He wanted to give everything to us I know you feel I abused him, but he wanted to give everything to us." AP1 confirmed she sold the resident’s van within the last two months for $40,000 and used the cash to pay for her kid's college tuition. AP1 confirmed her daughter was given the resident’s late wife’s wedding ring and she had it in her possession while talking to the investigator on the phone. AP1 stated the facility knew all about her relationship with the resident and they had allowed it to continue over several years.

During an interview, the resident's former power of attorney stated he always had a good relationship with the resident and when he noticed large amounts of money being given to AP1, he told the resident he shouldn't be giving her all that money. The resident became upset over this, and he later saw in the paper that his power of attorney was revoked and AP1 was named as a power of attorney. The resident's former power of attorney stated AP1 kept telling the resident stories about the war-torn country she came from and that she had breast cancer and what her family had been through and "As I look back on that statement, [the resident] got shmookered." AP1 brought her kids into the facility and he called them his grandchildren since the resident never had any kids "so he was really susceptible to that." The former power of attorney stated when the resident moved out of the assisted living, he and other family members couldn't go through any of the resident's belongings since AP1 and her family went through everything first; they threw away some, took some, and gave some items to other facility employees first. The resident's former power of attorney stated he told the facility AP1 had been taking money from the resident, but she was retained as an employee. The former power of attorney stated he knew the resident paid off AP1's mortgage and continued to give her and her family large amounts of money. The former power of attorney stated the resident was taking a large amount of cash out of the bank and he wasn't sure why he needed so much cash and assumed that also went to AP1 or other facility employees.

During an interview, the resident's sister stated she met AP1 around ten years ago and she had said, "If anyone's gonna get [the resident's] money, it's gonna be her. And it was her. She came in here with her four kids and they were calling him grandpa, it stunk to high heaven, but she got it." The resident's sister stated towards the end of the resident's life, he ran out of money and the resident commented to her that he hadn't seen AP1 in a while and "I said yeah, I bet not, your money's gone." The resident's sister stated she told management at the facility AP1 was taking money from her brother, but they still kept her as an employee. The resident's sister stated, "How could they just take my brother's money right in front of everyone and everyone just went along with it?"

During an interview, a facility employee stated the resident was a bit of a lonely guy after his wife died and AP1 began calling him dad and having her kids call him grandpa and he seemed to like the attention. The employee stated AP1 "kind of separated people, he was really close to [a family member] and she kind of divided people" that were close to the resident. The employee stated the facility was very aware of AP1's relationship with the resident and stated "a lot of people knew it was wrong, it made my stomach sick, it's illegal". The employee stated that people reported their concerns but there was nothing else they could do and AP1 was allowed to continue working. The employee stated the resident gave his wife's diamond ring to AP1's daughter after she died and after the resident moved to the nursing home, AP1 and her family cleaned out his assisted living apartment and took everything. The employee stated the resident often went to the bank and withdraw large amounts of cash and she had discouraged him from taking out so much cash. The employee stated the resident wouldn't have needed cash in the facility and she suspected he was giving cash to AP1 or other employees. The

employee stated the resident's financial power of attorney was also the resident's accountant and "even though he knew something was going on, he was aware something was going on" he did not investigate or take any action. The employee stated she had heard AP1 sold the resident's van for $75,000 recently.

An administrative employee stated they investigated concerns related to AP1 serving as the resident's POA in 2022 and their investigation concluded AP1 did not receive any large sums of money from the resident and since the resident had moved to the nursing home operated by the licensee, they felt AP1 could continue working at the assisted living and she was taken off suspension and brought back to work.

During an interview, AP2 stated she met the resident when she was a caregiver at the facility but only worked there for a few months in 2014. AP2 stated the resident would call her and ask for rides to appointments and she'd bring him out to her home in the country to visit or have lunch. AP2 stated the resident tried to find people who needed help and he was a very generous person. AP2 stated the resident would give her $1,000 checks for gas money and as thanks for giving him a ride to places. AP2 stated that you could try say no, but he insisted you take the money. AP2 stated she didn't think anyone would approach him and ask for money but "he would find people who he thought he could help, and he'd say, I can see you're going through a hard time, I'd like to help you a little bit." AP2 confirmed she accepted money from the resident, but only after she no longer worked for the facility.

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:
(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:
(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or
(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.
(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: No, deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: AP1 Yes, AP2 Yes

Action taken by facility:
Upon learning of allegations in 2022, the facility investigated the incident and reported it to MAARC. After the maltreatment investigation was initiated, the facility terminated AP1.

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
Roseau County Attorney
Roseau City Attorney
Roseau Police Department
Minnesota Board of Executives for Long Term Services and Supports

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30496	A. BUILDING: ____ B. WING ____	C 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE MEDICAL CENTER	**201 10TH STREET SE ROSEAU, MN 56751**

(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****** ASSISTED LIVING PROVIDER 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: #HL304961661M/ #HL304964727C On June 20, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. The following correction order is issued/orders are issued for #HL304961661M/ #HL304964727C, tag identification 0590, 2320, 2360.	0 000	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.	
0 590 SS=D	144G.42 Subd. 3 Facility restrictions (a) This subdivision does not apply to licensees	0 590		

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that are Minnesota counties or other units of government.
(b) A facility or staff person may not:
(1) accept a power-of-attorney from residents for any purpose, and may not accept appointments as guardians or conservators of residents; or
(2) borrow a resident's funds or personal or real property, nor in any way convert a resident's property to the possession of the facility or staff person.
(c) A facility may not serve as a resident's legal, designated, or other representative.
(d) Nothing in this subdivision precludes a facility or staff person from accepting gifts of minimal value or precludes acceptance of donations or bequests made to a facility that are exempt from section 501(c)(3) of the Internal Revenue Code.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to follow facility restrictions for one of one residents (R1). A facility staff person, unlicensed personnel (ULP)-A was named as the benefactor of the resident's Last Will and Testament, as well as the resident's health care power of attorney (POA). A facility board of directors member (BM)-D accepted a power of attorney for R1 and was named as the personal representative of the resident's Last Will and Testament.

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, but was not likely to cause serious injury, impairment, or death)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

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situation has occurred only occasionally).

The findings include:

ULP-A was hired on August 10, 2014, and was still currently employed as a ULP providing direct care and services to residents at the facility on June 20, 2024.

R1 admitted to the facility on March 13, 2010. The facility began operating under the assisted living license on August 1, 2021. The facility underwent a change on ownership on November 1, 2022.

R1 discharged from the facility on May 24, 2022, to a nursing home operated by the licensee.

R1's diagnoses included multiple sclerosis.

R1's face sheet dated March 1, 2021, indicated unlicensed personnel (ULP)-A and ULP-C were emergency contacts for R1, along with R1's brother in law. The face sheet indicated ULP-A was the health care power of attorney. The face sheet indicated BM-D was the power of attorney and executor.

R1's Assisted Living Resident Agreement dated July 30, 2021, indicated R1's designated representative was ULP-A and the legal representative as defined by Minnesota law was BM-D, the power of attorney.

R1's unsigned service plan dated March 1, 2022, indicated ULP-A was "emergency contact 1, friend, HCP, R" The service plan indicated BM-D was the resident's power of attorney and executor.

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0 590	Continued From page 3 R1's most recent assessment dated March 11, 2022, indicated the resident was hard of hearing, had anxiety, and was dependent on staff for transfers. R1's cognition was noted to have "other significant orientation concerns that require redirection...he does have intermittent confusion and disorientation. Staff redirect or call friends and he does better with this." The resident was noted to need occasional reassurance or redirection due to mild disorientation to person, place, or time. The assessment also indicated the "resident has progressing MS [multiple sclerosis]. He is being followed by home care, physical therapy, and occupational therapy. He has had an increase in confusion and intermittent disorientation. He becomes upset with these episodes. He will call friends and this will make him feel at ease. He is orientated after a short period of time and he knows he is having these episodes and this causes frustration for him as well." R1's individual abuse prevention plan (IAPP) dated March 11, 2022, indicated the resident was at risk for abuse due to his diagnosis of MS and intermittent confusion. He was noted to be "at risk for financial abuse from others due to his need for assistance with finances. He does have a POA for finances." The resident was noted to be paranoid and anxious at times. The resident had "a few POA friends and others that assist him with health and financial support." R1 was noted to "show signs of depression. He is having increased confusion and with his CA and MS diagnosis he does show these sides of decline. MD did start Zoloft for him and RN sent over his symptoms of depression last week. She requested he start Zoloft daily. Per his friend/POA [ULP-A], do not start until Monday due to the weekend and his possibility of paranoia over new	0 590		

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medication. Will discuss on Monday if this should be started." The IAPP indicated the resident had "intermittent confusion regarding where he is or what he is supposed to be doing. This is usually short term and comes out of it fine..."

R1's record contained a copy of a Power of Attorney dated March 27, 2018, which indicated "...I do hereby make, constitute, and appoint [BM-D], of the County of Roseau, State of Minnesota, my true and lawful primary attorney in fact, granting him the following enumerated powers and authority, to act in my name, place, and stead, on my behalf, and for my use and benefit..." The Power of Attorney document contained a signature from BM-B indicating he had "been nominated by the principal to act as an attorney-in-fact."

Court records indicated R1 named ULP-A in his Last Will and Testament dated March 27, 2018. Article III indicated "All the rest, residue, and remainder of my property, real, personal, and mixed, now owned or hereafter acquired by me of every nature whatsoever and whatsoever situated, of which I may die seized or possessed, or to which I may at the time of my death be in any way entitled, I give, devise, and bequeath to [ULP-A] or to her issue by right of representation. Article IV indicated R1 made "no provision, in this my Last Will and Testament, for my sister, or for any other persons whether relative or non-relative, and state that said omission is intentional and not through inadvertence." Article V read, "I hereby nominate and appoint [BM-D] as the personal representative of this, my Last Will and Testament, with full power to said personal representative to sell and convey, lease or mortgage any and all real estate of which I may die seized, without license or leave of court, and I

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direct my said personal representative to do each and every act and thing necessary to proper to the full and complete administration of this, my last Will and Testament. I request that my estate be administered in as informal a manner as my personal representative deems advisable. I also direct that my personal representative shall serve without bond."

A court record dated January 10, 2024, indicated there was conflict over whether or not R1 should be cremated after his death. ULP-A attended the court hearing. The Findings of Fact, Conclusions of Law and Order For Disposition of Human Remains, page two, section eight indicated, "Petitioner was advised by a number of non-relatives and by Descendent's sole divisee of his Will, [ULP-A], that descendent wished to be cremated."

R1's progress notes contained the following entries:
-February 23, 2022, "...He does do his own medications and this was discussed with caregivers and his POA and he wants to continue doing his own medications and allow him to be as independent as possible."
-March 11, 2022, "POA [ULP-A] came to writer today expressing her concern about depression/anxiety. RN did notice this as well today as RN was in there earlier doing assessments and visiting with him about his confusion. He does have home health setting up meds and he self administers. He has been having increased confusion and paranoia..."
-March 14, 2022, the resident's annual assessment was completed. "Staff have been noticing increased weakness at times with transfers. Discussed with [R1] regarding this as well as family/friend [ULP-A]. Both denied wanting

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0 590	Continued From page 6 additional assistance and risks/benefit was discussed about these services..." -March 28, 2022, "...Talked to POA, [ULP-A] today and discussed using pillows under his buttocks and having him lay back in his wheelchair. We also discussed having him obtain a sara steady non mechanical lift. He would pay for this and have in his room. Will discuss with home health and see what options are..." -March 31, 2022, "Visited with family, [ULP-A], and [R1] regarding resting and repositioning. He wishes to stop laying down after meals and sit in his chair throughout the shift. His buttock area is healing, but not completely healed. He does use a different wheelchair cushion and is educated about skin, barrier creams, accepting care from staff for skin care, and also repositioning. He does state he understands as does POA [ULP-A]..." -April 7, 2022, "Side rail assessment completed. Discussed risks/benefits of side rails with [R1] and POA [ULP-A] in his room..." -April 11, 2022, R1 fell in his room. "Discussed his weakness with family [ULP-A]. Will try to meet with home health, family, and others this week to discuss our options of care for [R1]. He is getting increasingly difficult to transfer and care for in assisted living care." -April 13, 2022, "...Visited with primary caregiver, [ULP-A], today as well. Discussion was had regarding need for two person transfer for [R1] and that he needs more assistance with cares... -May 10, 2022, "Home health and POA/family meeting with RN tomorrow to discuss his level of care and needing higher need of care. Will address this tomorrow at the meeting. In the meantime, POA will be available to help with any assistance he needs." -May 20, 2022, "Phone call from [hospice RN] today regarding [R1] and his move to skilled care.	0 590		

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0 590	Continued From page 7 [R1] is stable, but needing assistance of 1-2 people depending on the day. Family has been coming in twice a day, but it is not enough to keep him safe in the facility. [R1] is becoming weaker each day and has become incontinent of bowel and bladder. He was able to manage his continence, but over the past few weeks he has lost control of this aspect of function. He has services three times a day for assistance with repositioning and incontinence care, but has developed pressure sores from immobility and incontinence. Discussion was done in length with [hospice RN] regarding this and POA [ULP-A] aspect of his care. She has taken great care of [R1] and is always willing to help but is needing 24 hours of 2 person care that Oak Crest cannot provide for him." -May 24, 2022, R1 was discharged to a skilled nursing facility operated by the licensee. The licensee's internal investigation dated June 23, 2022, included the following: An administrator of the facility called a meeting with social services and one of R1's family members who was wondering what happened to R1's personal items after he moved to the skilled nursing facility. "[the social worker] from LifeCare Roseau Manor knew that ULP-A who also is a resident aide at Oak Crest where [R1] had previously resided for years) had possession of the Van. [ULP-A] told [social worker] that she was storing the van for [R1] to transport him. [ULP-A] also stated that the Van was still in [R1's] name. [social worker] is helping [R1] file for medical assistance and so he had stated he gifted the van to [ULP-A]. [social worker] also stated that there was a CD at the bank for [ULP-A's] children when he is gone....There is history here with [ULP-A] becoming POA. Past Director was involved and stated she was unable to be the POA. [R1]	0 590		

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0 590	Continued From page 8 involved lawyers and the lawyers deemed that he was of sound mind and stated that [ULP-A] could be over his medical but not over financial. [ULP-A] and her family cleaned out [R1's] apartment. They threw what they didn't want and took the rest, including the van. Stated [R1] had come to her (awhile back) and stated that [ULP-A] had cancer...payroll and was unaware of any medical leaves or time off for this. Stated that [R1's family member] had shared with her that a couple of times large sums of money were missing." On June 24, 2022, LALD-E and other administrative employees met with ULP-A on "what happened to all of [R1's] belongings and his vehicle. [ULP-A] stated that [R1] took what he wanted and told her to give the rest away. She did reach out to his family for them to come and get what they wanted and one family member did come-this was confirmed by a family member. She threw a bunch away and gave the rest to other staff members. She is currently storing the Van at her home, to use to transport [R1] when needed. (Van is specially altered to accommodate [R1's] scooter for transportation.) She also stated that she had 4-5 scooters of his stored. I (LALD-E) asked if she or anyone in her family was ever given any money of a monetary amount for example $100.00 or more. [ULP-A] stated yes, my kids at Christmas. An administrative employee asked was there any other larger amounts of money given? [ULP-A] replied yes. The administrative employee proceed with how much? [ULP-A] hesitated and said not much. Throughout the above conversation, [ULP-A] stated multiple times "He's like my father. I didn't do anything he didn't want me to do." The licensee placed ULP-A on administrative leave and filed a MAARC report. On June 29, 2022, the licensee "Provided all staff with the Gift and VA policies and questionnaire to review and turn	0 590		

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0 590	Continued From page 9 back page regarding the policies. (Questionnaire included requesting information if they had current or past concerns.) Interviewed 5 current residents and there were no new findings or concerns. LifeCare Social Services interviewed [R1] today. Through this interview it was very clear that the relationship between Him and [ULP-A] is a very special bond. They view each other as a Father/Daughter and he is Grandpa to her children. Both [R1] and [ULP-A] report to have a true and genuine relationship. [R1] stated that he has never felt coerced or persuaded into giving any gifts or money to any staff members at Oak Crest. When asked if he ever gifted money or belongings to a staff member at Oak Crest, He said it really doesn't matter because he can give money to whomever he wants." On July 1, 2022, the licensee determined "no other residents were affected by [ULP-A's] alleged actions. A legal consultation concerning [ULP-A's] employment was performed. [Administrative employee] and I [LALD-E] discussed and with the conclusion of the investigation we believe that the relationship between [ULP-A] and [R1] is genuine and mutual. The incident with [ULP-A] and [R1] seems to be an isolated incident. We feel that because [R1] no longer resides at Oak Crest that this is no longer a conflict of interest. We don't feel that [ULP-A] is a threat or a risk to our residents at Oak Crest Senior Housing. No time during the investigation did we find any evidence that [ULP-A] coerced or manipulated [R1]. [Administrative employee] and I [LALD-E] met with [ULP-A] and explained that the boundaries she crossed as a care giver with a resident are not allowed and they can not occur again. [ULP-A] understood and realizes this. [ULP-A] shared again that when [R1] moved, he wanted to give her the van and turn it into her name. She told him no that he couldn't do that. He also	0 590		

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wanted to give her his money and she told him no and refused that too. She wanted us to know that [R1] chose her and her family. He asked if he could be Grandpa to her kids. Him and his wife didn't have any children and he wanted to have them as his family. [Administrative employee] and I took [ULP-A] off her paid suspension and she will resume her scheduled shifts.

On June 20, 2024, at 11:00 a.m., ULP-A stated the resident "called me a daughter because he wanted nothing to do with his family...He wanted to help me and my family, he wanted us to be a real family with him, he wanted to adopt us." ULP-A stated she first met R1 when she worked at a clinic and R1 came in as a patient and she got to know him better when she was his caregiver at the assisted living facility. ULP-A was asked if her relationship with R1 while he lived at the assisted living facility was a conflict of interest or if the facility had ever told her the relationship was a conflict of interest. ULP-A stated the facility was well aware of her relationship with R1 and she was the emergency contact for the resident so the facility would call her with updates and she had never been told it was a conflict of interest.

On June 20, 2024, at 11:35 a.m., assistant administrator (AA)-F stated R1 would go out for holidays with ULP-A and he had claimed her as his daughter and her kids were his grandkids and they visited very frequently.

On June 24, 2024, at 10:05 a.m., LALD-E stated she got a phone call related to concerns with ULP-A and R1 so she had initiated an investigation in June 2022. LALD-E stated they had filed a MAARC report and submitted their investigation which concluded ULP-A did not receive any large sums of money from R1 and

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they never heard anything back or were told there were concerns with the conflict of interest so ULP-A was taken off suspension and brought back to work. LALD-E stated since R1 had moved to the skilled nursing facility which was operated by the licensee, they felt ULP-A could continue working for the licensee since he wasn't at the facility she was working at.

On June 26, 2024, at 11:45 a.m., facility employee (FE)-G stated R1 was a bit of a lonely guy after his wife died and ULP-A began calling him dad and having her kids call him grandpa and he seemed to like the attention. FE-G stated ULP-A "kind of separated people, he was really close to [a family member] and she kinda divided people" that had been close to the resident. FE-G stated the facility was very aware of ULP-A's relationship with R1 and "a lot of people knew it was wrong, it made my stomach sick, it's illegal" and people had reported their concerns but there was nothing else they could do.

The licensee's Conflict of Interest Organization Wide policy dated April 2012, indicated the licensee prohibited its employees from engaging in any activity, practice, or act that actually or potentially conflicts with or appears to conflict with the interests of LifeCare Medical Center or its patients/residents/clients. Employees should avoid any dealings, which would inhibit the impartiality of the employee's business judgment, place the employee or LifeCare Medical Center in an illegal, equivocal, embarrassing or ethically questionable position, or reflect unfavorably on the integrity of the organization. An employee who is about to engage in a relationship that might involve a conflict of interest, or an employee who has a close relative in such a situation, must immediately inform their manager, in writing, of

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0 590	Continued From page 12 the circumstances involved. This includes situations in which a conflict of interest may exist or just appears to exist. This information will be reviewed by the Administrative Council for a decision as to whether or not a conflict of interest is present, and if so, what course of action was to be taken. Failure to avoid or obtain authorization for a practice that may be a conflict of interest is a serious breach of LifeCare Medical Center's Code of Conduct and may result in disciplinary action. No further information was provided. TIME PERIOD FOR CORRECTION: SEVEN (7) DAYS	0 590		
02320 SS=G	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards when an unlicensed personnel (ULP)-A accepted money, a vehicle, and other personal items of value from R1. The facility investigated allegations of an inappropriate relationship that violated professional boundaries and the investigation confirmed the allegations.	02320		

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However, despite knowing ULP-A had violated professional boundaries, the licensee retained ULP-A as an employee. ULP-A continued to benefit financially from R1 and was still employed by the licensee at the time of the complaint investigation. In addition, another employee of the licensee, (ULP-C), maintained a relationship with R1 after she ended her employment and accepted at least $24,500 from the resident. ULP-C was named as an emergency contact for R1.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) 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).

The findings include:

R1 admitted to the facility on March 13, 2010. The facility began operating under the assisted living license on August 1, 2021. The facility underwent a change on ownership on November 1, 2022.

R1 discharged from the facility on May 24, 2022, to a nursing home operated by the licensee.

R1's diagnoses included multiple sclerosis.

R1's face sheet dated March 1, 2021, indicated ULP-A and ULP-C were emergency contacts for R1, along with R1's brother in law. The face sheet indicated ULP-A was the health care power of attorney. The face sheet indicated BM-D was the

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power of attorney and executor.

R1's Assisted Living Resident Agreement dated July 30, 2021, indicated R1's designated representative was ULP-A and the legal representative as defined by Minnesota law was board member (BM)-D, the power of attorney.

R1's unsigned service plan dated March 1, 2022, indicated ULP-A was "emergency contact 1, friend, HCP, R" The service plan indicated BM-D was the resident's power of attorney and executor.

ULP-A was hired on August 10, 2014, and was still currently employed as a ULP providing direct care and services to residents at the facility on June 20, 2024.

Court records indicated R1 named ULP-A in his Last Will and Testament dated March 27, 2018. ULP-A was also appointed power of attorney over the resident's health care at that time.

A letter to R1 from a law office used by R1 titled "Re: Revocation of Power of Attorney; New Power of Attorney and New List Will & Testament, dated March 28, 2018, read, "Following our meeting on March 27, 2018, I did call and speak with [family member (FM-B] regarding the revocation of the Power of Attorney. I advised [FM-B] that you and I had discussed the current status of the Power of Attorney recently and I based upon my conversations I recommended to you that a neutral person be appointed as the successor attorney in fact. I further advised [FM-B] that other than this limited information, due to our attorney/client privilege, I could not provide him with any additional information. [FM-B] did indicate to me that he was concerned about

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monies that may have already been paid to [ULP-A], and [FM-B] said that was in violation of the Employment Policies for Oak Crest Senior Housing where [ULP-A] is employed. As you and I discussed on March 27, 2018, Oak Crest does have policies prohibiting residents from gifting or tipping employees and/or their families, and further, a policy preventing employees and/or their families from accepting gifts or tips from residents. I further understand that you have given some items to [ULP-A] or her family and those items were to be returned..."

Bank records, including copies of checks, indicated the following:

ULP-A received $117,295 from R1 and her family members received $58,700. In total, ULP-A and her family received $175,995 around the time she accepted power of attorney over the resident's health care.

ULP-A received three checks totaling $48,000 from R1, one for $10,000, another for $18,000, and another for $20,000, over a year period that had "Meds" Med Bills" or "Medical" written on the memo line.

The licensee's internal investigation dated June 23, 2022, included the following: An administrator of the facility called a meeting with social services and one of R1's family members who was wondering what happened to R1's personal items after he moved to the skilled nursing facility. "[the social worker] from LifeCare Roseau Manor knew that ULP-A who also is a resident aide at Oak Crest where [R1] had previously resided for years) had possession of the Van. [ULP-A] told [social worker] that she was storing the van for [R1] to transport him. [ULP-A] also stated that the

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02320	Continued From page 16 Van was still in [R1's] name. [social worker] is helping [R1] file for medical assistance and so he had stated he gifted the van to [ULP-A]. [social worker] also stated that there was a CD at the bank for [ULP-A's] children when he is gone....There is history here with [ULP-A] becoming POA. Past Director was involved and stated she was unable to be the POA. [R1] involved lawyers and the lawyers deemed that he was of sound mind and stated that [ULP-A] could be over his medical but not over financial. [ULP-A] and her family cleaned out [R1's] apartment. They threw what they didn't want and took the rest, including the van. Stated [R1] had come to her (awhile back) and stated that [ULP-A] had cancer...payroll and was unaware of any medical leaves or time off for this. Stated that [R1's family member] had shared with her that a couple of times large sums of money were missing." On June 24, 2022, LALD-E and other administrative employees met with ULP-A on "what happened to all of [R1's] belongings and his vehicle. [ULP-A] stated that [R1] took what he wanted and told her to give the rest away. She did reach out to his family for them to come and get what they wanted and one family member did come-this was confirmed by a family member. She threw a bunch away and gave the rest to other staff members. She is currently storing the Van at her home, to use to transport [R1] when needed. (Van is specially altered to accommodate [R1's] scooter for transportation.) She also stated that she had 4-5 scooters of his stored. I (LALD-E) asked if she or anyone in her family was ever given any money of a monetary amount for example $100.00 or more. [ULP-A] stated yes, my kids at Christmas. An administrative employee asked was there any other larger amounts of money given? [ULP-A] replied yes. The administrative employee proceed with how	02320		

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02320	Continued From page 17 much? [ULP-A] hesitated and said not much. Throughout the above conversation, [ULP-A] stated multiple times "He's like my father. I didn't do anything he didn't want me to do." The licensee placed ULP-A on administrative leave and filed a MAARC report. On June 29, 2022, the licensee "Provided all staff with the Gift and VA policies and questionnaire to review and turn back page regarding the policies. (Questionnaire included requesting information if they had current or past concerns.) Interviewed 5 current residents and there were no new findings or concerns. LifeCare Social Services interviewed [R1] today. Through this interview it was very clear that the relationship between Him and [ULP-A] is a very special bond. They view each other as a Father/Daughter and he is Grandpa to her children. Both [R1] and [ULP-A] report to have a true and genuine relationship. [R1] stated that he has never felt coerced or persuaded into giving any gifts or money to any staff members at Oak Crest. When asked if he ever gifted money or belongings to a staff member at Oak Crest, He said it really doesn't matter because he can give money to whomever he wants." On July 1, 2022, the licensee determined "no other residents were affected by [ULP-A's] alleged actions. A legal consultation concerning [ULP-A's] employment was performed. [Administrative employee] and I [LALD-E] discussed and with the conclusion of the investigation we believe that the relationship between [ULP-A] and [R1] is genuine and mutual. The incident with [ULP-A] and [R1] seems to be an isolated incident. We feel that because [R1] no longer resides at Oak Crest that this is no longer a conflict of interest. We don't feel that [ULP-A] is a threat or a risk to our residents at Oak Crest Senior Housing. No time during the investigation did we find any evidence that [ULP-A] coerced or manipulated [R1].	02320		

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02320	Continued From page 18 [Administrative employee] and I [LALD-E] met with [ULP-A] and explained that the boundaries she crossed as a care giver with a resident are not allowed and they can not occur again. [ULP-A] understood and realizes this. [ULP-A] shared again that when [R1] moved, he wanted to give her the van and turn it into her name. She told him no that he couldn't do that. He also wanted to give her his money and she told him no and refused that too. She wanted us to know that [R1] chose her and her family. He asked if he could be Grandpa to her kids. Him and his wife didn't have any children and he wanted to have them as his family. [Administrative employee] and I took [ULP-A] off her paid suspension and she will resume her scheduled shifts. On June 20, 2024, at 11:00 a.m., ULP-A stated she understood as an employee she could not accept any gifts but "my situation with him was so different. Until he died, I was taking care of him, til his last breath. He called me a daughter because he wanted nothing to do with his family...He wanted to help me and my family, he wanted us to be a real family with him, he wanted to adopt us." ULP-A stated she first met R1 when she worked at a clinic and R1 came in as a patient and she got to know him better when she was his caregiver at the assisted living facility. ULP-A was asked if R1 had ever given her money and if so, how much. ULP-A stated he had given her some money. ULP-A was asked if R1 had ever written checks to her husband or other family members. ULP-A stated no, R1 had never written checks to her husband. ULP-A was told the investigator had copies of checks R1 had written to her husband with some amounts above $10,000 and if her answer was truthful. ULP-A stated that R1 had written checks to her husband occasionally and her kids got $500 checks for Christmas one year.	02320		

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02320	Continued From page 19 ULP-A stated R1 wanted to give his money to her and "you can ask every here, we were so connected. He'd come to my house, I'd go visit him every single day...we were so close." ULP-A was asked if her relationship with R1 while he lived at the assisted living facility was a conflict of interest or if the facility had ever told her the relationship was a conflict of interest. ULP-A stated the facility was well aware of her relationship with R1 and she was the emergency contact for the resident so the facility would call her with updates and she had never been told it was a conflict of interest. ULP-A was asked how much money R1 had given her and she stated she wasn't sure. ULP-A was asked if it was over $10,000 and she stated yes. ULP-A was asked if it was over $50,000 and stated "Yes, it was a lot of money but I don't know the exact amount." ULP-A was told by the investigator that it appeared at least $200,000 had been given to her and if that would be accurate. ULP-A stated, "I feel like he was my dad and I don't know, he just wanted to give it to us. He wanted to give it to me and my kids." ULP-A stated R1 told her "It's my money, I can give it to who I want." ULP-A confirmed she did not disclose the truth when interviewed by the facility in 2022 because R1 "didn't want anybody to know. He wanted to give everything to us I know you feel I abused him but he wanted to give everything to us." ULP-A confirmed she sold R1's van within the last two months for $40,000 and used the cash to pay for her kid's college tuition. On June 20, 2024, at 11:35 a.m., assistant administrator (AA)-F stated she primarily works at the skilled nursing facility but had assisted with the 2022 investigation. AA-F stated had they been aware that at the time they interviewed ULP-A in 2022 she had already received almost	02320		

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$200,000 from R1, it would have changed the outcome of their investigation. AA-F stated R1 would go out for holidays with ULP-A and he had claimed her as his daughter and her kids were his grandkids and they visited very frequently.

On June 24, 2024, at 10:05 a.m., LALD-E stated she got a phone call related to concerns with ULP-A and R1 so she had initiated an investigation in June 2022. LALD-E stated they had filed a MAARC report and submitted their investigation which concluded ULP-A did not receive any large sums of money from R1 and they never heard anything back or were told there were concerns with the conflict of interest so ULP-A was taken off suspension and brought back to work. LALD-E stated since R1 had moved to the skilled nursing facility which was operated by the licensee, they felt ULP-A could continue working for the licensee since he wasn't at the facility she was working at.

On June 26, 2024, at 11:45 a.m., facility employee (FE)-G stated R1 was a bit of a lonely guy after his wife died and ULP-A began calling him dad and having her kids call him grandpa and he seemed to like the attention. FE-G stated ULP-A "kind of separated people, he was really close to [a family member] and she kinda divided people" that had been close to the resident. FE-G stated the facility was very aware of ULP-A's relationship with R1 and "a lot of people knew it was wrong, it made my stomach sick, it's illegal" and people had reported their concerns but there was nothing else they could do. FE-G stated R1 gave his wife's diamond ring to ULP-A's daughter after she had died and after the resident moved to the nursing home, ULP-A and her family cleaned out his assisted living apartment and took everything. FE-G stated R1's financial power

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of attorney, BM-D, was also the resident's accountant and "even though he knew something was going on, he was aware something was going on" he did not investigate or take action.

On June 27, 2024, at 10:10 a.m., ULP-A denied saying she had cancer and stated she was never diagnosed with cancer at any point. ULP-A was asked why there would be three checks designated to medical expenses and stated that R1 had given her that money to cover any medical expenses the family might incur like a dentist visit or doctor's visit. ULP-A stated she never told R1 she had cancer. ULP-A confirmed she had cleaned out R1's assisted living apartment and the apartment was mostly old papers and books. ULP-A stated assisted living facility management was aware she was cleaning out the apartment and had watched her clean it out and they never tried to stop her or say she couldn't do that. ULP-A stated the resident's van was in his name and the title was not transferred until after his death. ULP-A stated once the van was put in her name, she sold it. ULP-A stated she didn't think she had a diamond ring but would have to ask her daughter if she ever got one. While on the phone with the investigator, ULP-A asked her daughter if she got a ring from R1 and confirmed that she was given his late wife's ring for her 14th birthday. ULP-A confirmed she had the ring in her possession and that it was only a very simple ring.

ULP-C

ULP-C accepted $24,500 in checks from R1, however the checks were not given to ULP-C until after she had resigned her position from the facility. From March 31, 2016, through February 24, 2018, R1 wrote 24 checks to ULP-C.

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02320	Continued From page 22 On June 24, 2024, at 12:05 p.m., ULP-C stated she met R1 when she was a caregiver at the facility but had only worked there for a few months in 2014. ULP-C stated R1 would call her and ask for rides to appointments and she'd bring him out to her home in the country to visit or have lunch. ULP-C stated R1 would try find people who needed help and he was a very generous person. ULP-C stated R1 would give her the $1,000 checks for gas money and as thanks for giving him a ride to places and you could try say no but he would insist you take the money. ULP-C stated she didn't think anyone would approach him and ask for money but "he would find people who he thought he could help and he'd say I can see you're going through a hard time, I'd like to help you a little bit." ULP-C confirmed she accepted money from R1, but it was only after she no longer worked for the facility. The licensee's undated Gifts To Staff And Staff Recognition policy indicated staff were not to accept any individual gifts from residents, resident's representatives or their families, except for non-monetary gifts of minimal value, such as home-made baked goods, crafts or cards. If a gift was offered or given, staff were to notify their supervisor. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 23 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 residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and an individual person were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	