Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307637810M
Compliance #: HL307634726C

Date Concluded: March 8, 2024

Name, Address, and County of Licensee Investigated:
Gracepoint Crossing
1545 River Hills Parkway Northwest
Cambridge, MN 55008
Isanti County

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

Evaluator's Name: Brandon Martfeld, RN BSN
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), a facility staff, financially exploited resident #1, resident #2, resident #3, and resident #4 when the AP either took money from and/or gained access to bank account information to remove money from the residents' bank accounts.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP was able to gather personnel information from resident #2, resident #3, resident #4, and an additional resident, resident #5, who resided at the facility. The information allowed the AP to electronically withdraw money from the residents' bank accounts and deposit money into a mobile payment service account (cash application) owned by the AP. Due to information provided by resident #1's family, it was not substantiated the AP financially exploited resident #1 by taking the resident's wallet and $10.00.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also interviewed residents and residents' family members. The investigator contacted law enforcement and interviewed the AP. The investigation included review of the residents' records, facility internal investigations, the AP's personnel file, staff schedules, the law enforcement report, and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

Resident #1 resided in an assisted living memory care unit. Resident #1's diagnoses included dementia and mild cognitive impairment. Resident #1's service plan included assistance problem solving. Resident #1 had moderately impaired memory, was at risk for financial abuse, and needed assistance from a family member with financial decisions.

Resident #2 resided in an assisted living memory care unit. Resident #2's diagnoses included Alzheimer's dementia. Resident #2 had moderately impaired memory, was at risk for financial abuse, and needed assistance from a family member with financial decisions.

Resident #3 resided in an assisted living facility. Resident #3's diagnoses included heart failure. Resident #3's service plan indicated the resident did not have scheduled services. Resident #3 had intact cognition, was independent with activities of daily living and finances.

Resident #4 resided in an assisted living facility. Resident #4's diagnoses included high blood pressure. Resident #4 service plan included assistance with homemaking and laundry. Resident #4 had intact cognition, was independent with activities of daily living and finances.

Resident #5 resided in an assisted living facility. Resident #5's diagnoses included macular degeneration (a disease that affects a person's central vision). Resident #5's service plan included assistance with homemaking and medication administration. Resident #5 had intact cognition, was independent with activities of daily living and finances.

Facility incident reports within one month, indicated the following investigations were completed by the facility involving the AP and financial exploitation of residents at the facility.

A facility's internal investigation revealed one day resident #1 reported the AP took his wallet and $10.00. The AP denied taking resident #1's wallet. The facility notified law enforcement.

A second facility internal investigation indicated resident #2 reported the AP asked for and was provided the resident's personnel identification information, including resident #2's social security number and date of birth. Resident #2 was able to describe the AP by her clothing and pointed the AP out to staff. Resident #2's family monitored the resident's debit card and were made aware the bank had blocked fraudulent electronic withdraws from the resident's account to a cash application. The AP denied asking resident #2 about identification information. The facility notified law enforcement.

A third facility internal investigation indicated, resident #3 reported missing $21.00 from his wallet. Ten days later, resident #3 noticed a $350.00 unauthorized electronic withdrawal from his bank account. At that time, the facility's internal investigation was unable to determine an AP. The facility notified law enforcement for a third time.

A fourth facility internal investigation indicated resident #4's family member reported the resident was missing $80.00 from her wallet. After resident #4 passed away, her family noted fraudulent activity on resident #4's bank account. The family reported someone withdrew $350.00 from resident #4's bank account and transferred the money into a mobile cash application. The facility notified law enforcement for a fourth time.

A fifth facility investigation indicated resident #5's family member reported fraudulent credit card charges in the amount of $489.00 dollars. The family reported there had been four attempts to withdraw money from the resident's credit card. During an interview, resident #5 stated she kept her purse in the bedroom and did not notice anyone go in her purse. Law enforcement was notified.

Review of staff schedules, indicated during a 12-day period of attempted money removal from the resident's accounts, the AP was employed at the facility and on the schedule.

During an interview, resident #1's family member stated the resident often misplaced his wallet. The family member said resident #1 did not have cash in the wallet and the family later found the wallet.

During an interview, resident #2 recalled having money missing a few months ago, however there had been no further concerns.

During an interview, resident #3 stated he was checking his bank account and noticed a withdraw of $350.00. Resident #3 stated he went to the bank and the money was credited back to him, but he never found out who or how it was taken. Resident #3 stated he left his wallet on top of the microwave and came home one day and was missing $21.00 from his wallet. Resident #3 stated the money from the account and the money missing from his wallet all happened about the same time. Resident #3 stated he had not withdrawn the $350.00 from his account.

During an interview, resident #4's family member stated the resident was in and out of the hospital and during that time, the resident reported to family she was missing money from her purse. After the resident passed away, the family member reviewed the resident's bank account and noticed a withdrawal of $350.00 from her bank account that was deposited into mobile cash application. The family member stated resident #4 did not have a mobile cash application

or know how to use the application. The family member stated they were not reimbursed the #350.00.

During an interview, resident #5's family member stated when shopping with the resident, the resident's credit card was declined. The family member called the resident's bank and was notified the resident's credit card was deactivated because of fraudulent charges. The bank told the family member multiple attempts had been made to withdraw $400.00 from resident #5's credit card for electronic deposit into a mobile cash application.

During an interview, leadership stated resident #2 identified the AP, and stated the AP asked for her social security number and date of birth. Leadership asked resident #2's family member to monitor resident #2's bank account information. The family reported to facility staff that three attempts had been made to remove money from resident #2's bank account. Leadership stated following the incident with resident #2, the facility notified residents and/or family members of the fraudulent activity.

Leadership stated staff selected five residents to interview about missing money. During the interviews, resident #3 stated he was missing $21.00, and someone had unsuccessfully attempted to withdraw $350.00 from his bank account. Resident #4's family member reported the resident was missing $80.00 from her wallet. After resident #4 passed away, the family reviewed her finances and discovered an unauthorized withdraw of $350.00 from resident #4's bank account. Leadership stated after the AP was no longer employed at the facility, there were no further incidences of fraud with any of the resident's bank accounts or missing money.

During an interview, the AP denied taking money from the residents. The AP also denied asking residents for identification information or taking money from resident's bank accounts and transferring money into a mobile cash application.

The law enforcement report indicated following their investigation it was determined the AP attempted or made fraudulent transactions from resident #2, resident #3, resident #4, and resident #5's bank accounts. The money was removed or attempted to be removed from the residents' accounts and electronically transferred into a mobile cash application that was attached to a specific phone type owned by the AP. The law enforcement report indicated the case was sent to the prosecutor for review.

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;
(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: Completed interviews with Resident #1, Resident- #2, and Resident #3. Resident-4 had passed away.
Family/Responsible Party interviewed: Completed interviews with Resident #1's Resident #4's and Resident #5's family members. Attempted to interview Resident #2's family. Resident #3 was responsible for himself.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility suspended the AP, completed internal investigations for each incident and sent out a letter to all residents and family members notifying of fraudulent activity. Facility leadership provided education to staff and notified law enforcement with each incident. The AP was no longer employed at 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.

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
Isanti County Attorney
Cambridge City Attorney
Cambridge Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30763	A. BUILDING: _____ B. WING _____	C 01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING	1545 RIVERHILLS PARKWAY NW CAMBRIDGE, MN 55008

(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: #HL307637810M/#HL307634726C On January 18, 2024, 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 66 residents receiving services under the provider's Basic Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for # HL307637810M/#HL307634726C, tag identification 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING	1545 RIVERHILLS PARKWAY NW CAMBRIDGE, MN 55008

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02360	Continued From page 1 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 five of five residents reviewed (R2, R3, R4, and R5) 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.	02360	No plan of correction is required for this tag.	