Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL343988004M
Compliance #: HL343985011C

Date Concluded: March 26, 2024

Name, Address, and County of Licensee Investigated:

Fortunate Homes LLC
7332 France Avenue North
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, 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), a facility staff member, financially exploited the resident when the AP used the resident's money to make personal purchases after becoming the resident's representative (rep) payee.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP admitted to taking approximately $15,000 of the resident's money. The AP requested to be the resident's representative (rep) payee, withdrew money from the resident's account, and used it for personal use.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the case manager. The investigation included review of the resident's records, facility documentation,

personnel files, a law enforcement report, and facility policies and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included psychosis, schizophrenia, and bipolar disorder. The resident's service plan included assistance with medication and behavioral management. The resident's assessment indicated the resident was susceptible to financial exploitation because of his inability to identify potentially dangerous situations and lack of insight into his financial situation. Interventions included open communication with the resident about concerns or questions he had regarding finances and the resident having assistance with his financing by choosing a rep payee.

Facility documents indicated the resident was supposed to received $20,000 in back pay from social security and a previous employee/alleged perpetrator (AP) of the facility was identified as the resident's rep payee. It was discovered that the AP brought the resident to the social security office and requested to be assigned as the resident's rep payee. During the AP's employment at the facility, the AP assisted residents with financial paperwork. After becoming the resident's rep payee, the AP resigned from her position at the facility and communication with the resident and facility staff decreased.

During an interview, the AP admitted to taking the resident's money for personnel use. The AP stated while she worked at the facility, she was responsible for spending time with residents, monitoring mental health symptoms, and assisting residents with filling out financial paperwork. The AP stated she went with the resident to the social security office to help him fill out paperwork and asked if she could be his rep payee. The AP stated she was in a bad relationship and withdrew approximately $15,000 from the resident's account over approximately six months. The AP stated the resident had approximately $300.00 left in his account and she was working on paying him back.

During an interview, the resident stated the AP helped him fill out financial paperwork and the AP asked to be his rep payee. The resident stated since the AP quit working at the facility, the resident did not have as much communication with the AP and the AP occasionally gave him money when he requested it. The resident stated the AP managed his bank statements, bills, and finances.

During an interview, facility management stated the AP helped the resident fill out social security paperwork which gave the AP knowledge of the amount of money the resident was supposed to receive. The AP drove the resident to the social security office and requested to be the resident's rep payee. The AP was not transparent with facility management that she became the resident's rep payee before she resigned from her position. Since then, the resident has had concerns about the AP overseeing his finances. The facility management felt the AP manipulated the resident and convinced him to not obtain a new rep payee. Facility management stated the AP was educated on maltreatment and resident boundaries prior to

the incident. After the incident, the facility completed an in-service on financial exploitation and employee code of conduct with all staff.

Review of the AP's employment file indicated the AP was trained on abuse prevention, resident boundaries, and the resident bill of rights.

Law enforcement was contacted and indicated there was an open investigation related to this incident.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation, provided staff education, reassessed the resident for vulnerabilities, and implemented additional interventions for resident protection.

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
Brooklyn Park County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34398	A. BUILDING: _____ B. WING _____	C 02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORTUNATE HOMES LLC	7332 FRANCE AVENUE NORTH BROOKLYN PARK, MN 55443

(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: #HL343985011C/#HL343988004M On February 26, 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 5 residents receiving services under the provider ' s Assisted Living license. The following correction order is issued for #HL343985011C/#HL343988004M, tag identification 2360.	0 000		
02360 SS=D	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.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, 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.	