Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL343218746M / HL344353482M
Compliance #: HL344352601C

Date Concluded: July 2, 2024

Name, Address, and County of Licensee Investigated:
Journeys Home Care LLC
5312 Queen Avenue North
Brooklyn Center, MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Maerin Renee, 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 the AP endorsed the resident's $500.00 money order and cashed it for herself.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The resident discovered a money order for $500.00 was missing. The money order was signed and cashed by the AP.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement. The investigation included review of the resident records, the facility internal investigation, facility incident reports, personnel files, staff schedules, the law enforcement report, and related facility policy and procedures. Also, the investigator observed staff interactions with residents.

The resident resided in an assisted living facility and received assistance with medication management, grooming, bathing, laundry, and housekeeping. The resident's assessment indicated the resident was alert and oriented with intermittent forgetfulness.

The facility internal investigation indicated the resident reported to facility leadership a $500.00 money order was missing and the resident put a trace on it to see if it had been cashed. The resident received a copy of the cashed money order in the mail and discovered the AP had endorsed and cashed the check for herself. The resident showed the copy of the money order to leadership who then filed a vulnerable adult report and helped the resident file a police report. The next day, leadership received a text from the AP, stating she would not be in to work that day. Leadership responded to the AP they were aware the AP endorsed and cashed the resident's money order and instructed the AP to not return to the facility. The facility reimbursed the resident $500.00.

A copy of the endorsed money order provided for the investigation indicated the AP had signed and cashed it for herself.

The police report indicated the AP was charged with 609.631.2(1) Check Forgery-Make or Alter a Check, a felony. The police report indicated the AP said she found the blank money order on the grounds of the facility, cashed it at a Western Union, and spent the money. The police officer showed the AP a copy of the endorsed money order, and the AP acknowledged the signatures were hers. The AP said the resident mentioned she was missing a money order and believed someone stole it. The police officer asked the AP why she did not notify the resident or someone else that she [the AP] was the one who cashed the money order, and the AP did not answer.

When interviewed, a nurse stated the resident told her and other staff she had lost a $500.00 money order. After the resident was unable to locate the money order, she put a trace on the money order to see if anyone had cashed it. When the resident received the copy of the cashed money order, she showed it to the nurse, and she saw the money order had been endorsed by the AP. The nurse filed a MAARC report and called the police. The nurse stated she sent the AP a text message and told her they were aware the AP took the resident's money order, and the AP should not return to the facility.

When interviewed, the AP stated she found a blank money order at the facility and cashed it since there was no name on the money order. The AP said the resident was telling others he lost a money order. The AP stated she realized the $500.00 money order belonged to the resident; however, she did not inform anyone she cashed the money order.

When interviewed, the resident stated she purchased three money orders for $500.00 each and kept them in her wallet inside of her purse. The resident said when she went to cash the final money order and it was gone. The resident and staff searched for the missing money order but

could not locate it. The resident stated she contacted the company that issued the money orders and placed a trace on the missing money order. When the resident received a copy of the missing money order, she discovered the AP had endorsed the money order to herself and cashed it. The resident stated the AP was aware the resident was missing a money order. . The resident stated she reported the AP to facility leadership.
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: Yes.
Family/Responsible Party interviewed: No, the resident is her own guardian.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an investigation. The AP is 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
Hennepin County Attorney
Brooklyn Center City Attorney
Brooklyn Center Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34435	A. BUILDING: _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURNEYS HOME CARE LLC	5312 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430

(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: #HL344352601C/#HL344353482M On June 6, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 4 residents receiving services under the provider's Assisted Living license. The following correction order is issued issued for #HL344352601C/#HL344353482M, tag identification 2360.	0 000		
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.	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 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.	02360	No plan of correction is required for this tag.	