Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL385802223M
Compliance Report #: HL385803971C

Date Concluded: September 13, 2022

Name, Address, and County of Licensee Investigated:
Valley View Estates
1104 4th Avenue Northeast
Long Prairie, MN 56347
Todd County

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

Evaluator's Name: Lissa Lin, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:
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 a resident when she asked him to buy her cigarettes with her debit card and PIN number (personal identification number). The AP made multiple unauthorized purchases with the resident's debit card.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP used the resident's debit card for unauthorized purchases for himself. The AP was trained on maltreatment and abuse of vulnerable adults. The AP was aware his actions went against the facility policy on handling resident finances.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted law enforcement, the resident's bank, and the

resident's family member. The investigation included review of the resident record, personnel records, policies, and procedures, bank records and police reports and transcripts of interviews with the AP and the resident.

The resident resided in an assisted living facility. The resident's diagnoses included major depressive disorder, Parkinson's, and dementia. The resident's service plan included assistance with bathing and showering and medication administration. The resident's assessment indicated she could communicate clearly, had occasional disorientation and was at risk for abuse.

One day, the resident and her family member, who was her power of attorney, went to the resident's bank. During the bank visit, the family member checked the resident's account balance, and it was nearly $1400 hundred dollars less than the balance was a few months earlier when the account was opened. The family member asked the resident what happened to the money and the resident said she had shared her debit card and PIN with the AP so he could buy her cigarettes. They closed the bank account and reported the incident to facility management and law enforcement.

Bank statements for the resident's account showed nearly two dozen purchases and ATM cash withdrawals made with her debit card over two months.

During a law enforcement interview with the resident and her family member, the resident said she never went to the bank to withdraw money from her account. The resident said she asked the AP for a cigarette sometimes and he did not have any, so she asked if he would buy her cigarettes, pop, or a sport drink for her at the nearby gas station. She told the AP he could also buy himself cigarettes and a pop if he wanted. She told police she never gave the AP permission to withdraw cash at ATMs or make purchases at stores other than the gas station. The resident said she knew about $1400 was missing from her account. The resident also told law enforcement the AP sometimes kept her card for a few days or over a weekend before returning it to her. She said the AP never gave her cash from the ATM withdrawals he made or gave her the unauthorized items he bought with her card. The resident said the AP often called her "darling" or "sweetheart" and rubbed her back (she was clothed). She said it made her uncomfortable, but she never told management about the AP's actions.

During a law enforcement interview, the AP stated he bought cigarettes for the resident numerous times. She had not given him permission to buy other items with her debit card. He told law enforcement the resident gave him permission to buy gas for his car with her debit card even though he stated he knew he should not have done that. The AP told law enforcement he withdrew about $400 at an ATM for the resident because she needed cash but did not specify how much cash she wanted. The AP continued to withdraw additional sums of money from the resident's account by ATM. He told law enforcement he spent some of the money and gave the resident some of the money. He did not recall all the purchases he made with the resident's debit card or cash; he denied buying an air conditioner with the resident's

money. The AP told law enforcement he was aware of a facility policy against using resident finances to make purchases and he went against the policy because he was a nice guy trying to help someone.

During an interview, the AP said the resident asked him numerous times to buy her cigarettes. He said he reluctantly took her debit card and PIN because it was against facility policy. The AP purchased cigarettes, pop, and “female items” for the resident at local stores. The AP said he did not use the resident’s debit card to purchase anything for himself and gave her receipts for everything he bought her. Later in the interview, the AP said while he was out shopping for the resident, he bought gas for his car with the resident’s debit card, but he had her permission. The AP said he thought he had built up a trust relationship with the resident and does not know why she is doing this to him. The AP said he had been warned by management before about buying anything for residents. The AP stated he was interviewed by law enforcement, has a court date and is going to pay back all the money the resident claimed he took. The AP stated financial exploitation happened.

During an interview, facility management said the resident told him she did not give anyone else her debit card and PIN or leave her card out in the open; only the AP had her information. When management met with the AP about the incident, the AP denied making purchases for the resident. Then the AP said he never took her debit card out of the facility but did purchase cigarettes for her at local stores. The AP denied using the resident’s card at ATMs for cash withdrawals. Management suspended the AP from work and banned him from the facility pending an investigation.

The resident’s family member said the resident was not capable of caring for herself. She was not supposed to smoke cigarettes because of her Parkinson’s. The family member stated she “almost had a heart attack” when the resident told her she had given the AP her debit card and PIN. She and the bank are monitoring it for any more unauthorized activity. The family member said the resident still does not fully grasp the AP would use her debit card for his own use.

In conclusion, financial exploitation was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means: (1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult.

Vulnerable Adult interviewed: No. Family member (POA) said resident’s cognition is an issue.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Facility management suspended the AP during internal investigation. The AP is no longer employed at facility. Law enforcement was notified.

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.

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
Todd County Attorney
Long Prairie City Attorney
Long Prairie Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38580	A. BUILDING: _____ B. WING _____	C 08/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL385803971C #HL385802223M On August 17, 2022, the Minnesota Department of Health conducted a desk complaint investigation on the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 22 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL385803971C/#HL385802223M, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Licensing 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, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment	02360		

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02360	Continued From page 1 covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was financially exploited. Findings include: On September 13, 2022, the Minnesota Department of Health (MDH) issued a determination that financial exploitation occurred, and that the individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	