Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL391277544M
Compliance #: HL391274145C

Date Concluded: 3/29/2024

Name, Address, and County of Licensee Investigated:
Goodhue Living
108 County 9 Boulevard
Goodhue, MN, 55027
Goodhue County

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

Evaluator's Name: Michele Larson RN, Special Investigator
Kathy Barnhardt 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), contracted staff, financially exploited resident #1 and resident #2 when the AP stole an engagement ring and a Black Hills gold mother's ring (total value $3,000) from resident #1, and $145.00 cash from resident #2.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP was scheduled to work in the memory care unit of the facility however, facility security cameras recorded the AP exiting resident #1 and resident #2's apartment on the assisted living side of the facility where he was not scheduled to work and had no reason to be in their apartments. A signed receipt from a local pawn shop indicated the AP pawned a Black Hills gold ring matching resident #1's ring.

The investigator conducted interviews with resident #1, resident #2, facility staff members, including administrative staff, nursing staff, unlicensed staff and contacted law enforcement. The investigators reviewed the AP's personnel file and the staffing agency's schedules. The investigation included review of resident #1 and resident #2's records, facility internal investigation, facility incident reports, staff schedules, law enforcement reports, and related facility policy and procedures.

Resident #1 resided in the assisted living side of an assisted with memory care facility. Resident #1's diagnoses included diabetes. Resident #1's service plan indicated she received assistance with housekeeping, laundry, and daily safety checks, was alert and oriented with no memory issues and walked independently.

Resident #2 resided in the assisted living side of an assisted living with memory care facility. Resident #2's diagnoses included pancreatic cancer and chronic pain. Resident #2's service plan indicated he received assistance with repositioning, transportation, medication administration, laundry, and housekeeping. Resident #2 was alert and oriented with no memory issues and used a walker for mobility.

Review of the facility staff schedule indicated the AP was assigned to work in the memory care unit one evening shift from 2:00 p.m. until 10:15 p.m. along with another facility unlicensed personnel (ULP).

Review of the facility's investigation indicated the following day after the AP's evening shift, resident #1 reported to the facility her diamond engagement ring and a Black Hills gold mother's ring were missing from her apartment. Review of the security camera footage from the previous evening shift recorded the AP entering resident #1 and resident #2 apartments when he had no reason to enter. The investigation also revealed resident #2 was missing $145.00 from the previous evening shift. Police reports were filed, and recorded security camera footage was turned over to law enforcement.

The law enforcement report indicated when law enforcement reviewed the camera footage from the evening of the alleged financial exploitation, the camera recorded resident #1 leaving her apartment on third floor at 5:06 p.m. Twelve minutes later, security camera footage recorded the AP entering resident #1's apartment for a total of four minutes. The AP immediately entered another resident's apartment across the hall. One minute later, the security camera footage recorded the AP counting something in his hands as he walked to the elevators and disappeared from the camera view. One minute later, the security camera footage recorded the AP entering resident #2's apartment located on the second floor. Two minutes later, resident #2 returned to his room where he confronted the AP. The AP told resident #2 he was in his apartment to empty resident #2's garbage. Seven minutes later, the security camera footage recorded the AP exit the facility and walk to his vehicle parked in the facility parking lot.

The law enforcement report indicated, resident #1 stated her rings were kept in a small, white box inside a dresser drawer. Resident #1 stated when she returned to her apartment the previous evening, she found her rings were missing and replaced with a piece of costume jewelry. Resident #2 stated the AP was in his apartment the previous evening when he returned from the dining room, stating he found the encounter to be “off.” The AP told police he was assigned to work the memory care unit that shift. The AP stated it was the AP’s customary practice to introduce himself to residents and knock on their doors before entering their apartments and leave if the residents were not there, stating he had no purpose to stay in their apartments. The AP had no explanation for the security camera footage recording him staying in resident’s apartments. In addition, facility supervisors confirmed the AP was not scheduled to work on that side of the facility. The AP did not admit to stealing resident #1’s rings and resident #2’s money.

Review of an on-line web site used by law enforcement to locate stolen property in pawn shops, indicated 50 days after the incidents, the AP pawned a Black Hills gold ring for $50.00. The receipt for the pawned ring was signed by the AP. The web site contained a photo of the Black Hills gold ring matching the description of resident #1’s ring. The ring was returned to resident #1.

During an interview, unlicensed personnel (ULP) stated she recalled working with the AP in the memory care unit that shift and wondered where he was, stating he should have stayed in the memory care unit. The ULP stated, “I could not find him (AP) if I needed help.” The ULP stated she saw the AP go out to his vehicle a few times during the shift, and stated another coworker asked her where the AP was multiple times. The ULP stated during the shift, “I would say 70% of the time the AP was missing, and 30 % he was in memory care.”

During an interview, administrative (AD) staff stated they were able to see the AP on recorded security cameras entering resident #1 and resident #2’s apartments when they were not there, stating there was no reason for the AP to be in their apartments. The AD stated the facility immediately contacted the AP’s staffing agency to inform them about the seriousness of the AP’s actions and the AP was not allowed back at their facility.

During an interview, resident #1 stated she took her rings off before she went downstairs to eat supper in the facility dining room. Resident #1 stated she did not notice the rings were missing until the following day when she discovered her engagement ring was replaced with a costume jewelry ring. The resident stated she checked another drawer, and her Black Hills gold mother’s ring was missing. Resident #1 stated prior to the incident she recalled seeing the AP walk through the dining room while she ate dinner. Resident #1 stated staff were not supposed to enter residents’ apartments if they were not there.

During an interview, resident #2 stated the AP was in his apartment when he returned from the dining room. Resident #2 stated the AP told him he was there to pick up garbage, however, the AP had no garbage bags in his hand. The AP returned to the apartment to check for garbage

bags then left. Resident #2 stated his wife thought the AP's explanation sounded suspicious so resident #2 counted the money in his wallet and was missing $145.00.

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. Both resident #1 and resident #2 were interviewed.
Family/Responsible Party interviewed: No, both residents are their own representatives.
Alleged Perpetrator interviewed: The AP did not respond to the investigators phone calls, voice messages, and email. A subpoena was sent to the AP but returned undeliverable.

Action taken by facility:
After the incident, the AP was not allowed back at the facility. The facility conducted an internal investigation, contacted law enforcement, and immediately filed a Minnesota Adult Abuse Reporting Center (MAARC) report.

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
Goodhue County Attorney
Goodhue City Attorney
Goodhue County Sheriff's Department
Minnesota Department of Human Services (DHS)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39127	A. BUILDING: _____ B. WING _____	C 02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOODHUE LIVING	108 COUNTY 9 BOULEVARD GOODHUE, MN 55027

(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****** HOME CARE PROVIDER/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: HL391274145C/#HL391277544M On February 7, 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 12 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL391274145C/#HL391277544M, 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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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 two of two residents reviewed (R1 and R2) 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.	