DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL24032001M
Compliance #: HL24032002C

Date Concluded: December 1, 2022

Name, Address, and County of Facility Investigated:
Eagle Crest Arbor
2945 Lincoln Drive
Roseville, MN 55113
Ramsey County

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

Evaluator's Name: Lori Pokela R.N.
Special Investigator

Finding: Inconclusive

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.

Allegation(s):
The staff member/alleged perpetrator (AP) financially exploited the client when the AP took money out of the resident's purse for their own personal use.

Investigative Findings and Conclusion:
Financial exploitation was inconclusive. Although the resident's money was missing, no specific AP could be identified. Following the incident, the resident's family purchased a safe for secure storage of the resident's money. No further incidents have occurred.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted law enforcement and the outside agency caregiver. The investigation included review of video footage, facility resident records, including medication records and facility policies and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included dementia, osteoporosis, and chronic kidney disease. The resident's medical records indicated the resident had short and long-term memory impairments. The resident's service plan indicated the resident required staff assistance with medication management and activities of daily living (ADLs) including dressing, grooming, toileting, and bathing. The resident also received services from a non-facility (outside) agency caregiver for transportation and assistance with personal errands and appointments. The resident's family assisted with management of the resident's finances.

The resident's non-facility caregiver brought the resident to an appointment and to the bank where the resident withdrew money. Two days after withdrawing cash from the bank, the resident discovered money was missing from her purse. The next day, the resident reported the missing money to the caregiver, who alerted the facility.

Upon learning of the missing money, the facility began an internal investigation and offered to contact law enforcement. The resident declined to file a police report.

The facility's internal investigation included an interview with the resident. The resident reported she witnessed a Caucasian, female staff member, with tattoos on her arms, "rifling" through her purse the day before the money was missing. Staffing schedules were reviewed and the facility determined no staff fit the description of the AP provided by the resident.

The internal investigation included staff interviews which identified a specific staff member/alleged perpetrator (AP), who was not assigned to care for the resident, enter the resident's room the day of the reported incident.

Review of video footage confirmed staff interview reports that the AP entered the resident's room on the day of the alleged incident; however, no video footage was available from within the resident's room. The facility was unable to determine if the AP took money from the resident's purse.

Attempts to contact the AP were unsuccessful.

Following this incident, the facility offered to install a camera in the resident's room and offered to provide a safe-box for storage of money and personal items. The resident declined.

During an interview, the facility administrative staff stated the AP did not fit the description provided by the resident and did not have tattoos.

During an interview, the resident's family stated the resident had not reported to be missing any money. The family member was informed of the incident by facility staff. The resident's family indicated the resident refused to have a camera placed in her room, so they purchased a

small safe for her to store money and no further incidents have occurred. The family had no concerns with the care provided at the facility.

In conclusion, it was inconclusive as to whether financial exploitation occurred.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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: No, deceased.
Family Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Attempts to contact the AP were unsuccessful.

Action taken by facility:
The facility reported and investigated the incident. The resident declined administration's offers to contact law enforcement, install a camera in her room, and provide a safe for storage.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc: The Office of Ombudsman for Long-Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24032	A. BUILDING: _____ B. WING _____	C 10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE CREST ARBOR	2955 LINCOLN DRIVE ROSEVILLE, MN 55113

(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 On October 6, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL24032002C/#HL24032001M. No correction orders are issued.	0 000		