Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL284386402M
Compliance #: HL284389548C

Date Concluded: November 27, 2024

Name, Address, and County of Licensee Investigated:

VitaCare Living
540 East Isle Street
Isle, MN 56342
Mille Lacs County

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

Evaluator's Name: Lena Gangestad, 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 by stealing and spending $3,353.02 using the resident's debit card at restaurants, gas stations, and liquor stores, as well as paying her internet bill.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for maltreatment. Although the AP denied the allegation, the police reviewed video surveillance from the various stores where the resident's card was used for unauthorized transactions. The user of the card was identified as the AP, who worked as an unlicensed caregiver at the facility.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigation included review of the resident's records, internal

investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses included dementia. The resident's service plan included assistance with all activities of daily living which included hygiene, dressing, toileting, medications, meals, and housekeeping. The service plan also indicated the family managed the finances, as the resident required assistance with financial matters.

One day, a family member received the resident's bank statement and questioned charges made at places the resident had never been before.

The police report indicated a family member of the resident reported several unauthorized charges on the resident's debit card, totaling $3,353.02. According to the report, the suspect [the AP] used the resident's card to pay a Verizon Wireless phone bill, even though the resident did not own a cell phone. Additionally, the report indicated the police officer confirmed with the city assistant clerk the resident's debit card had been used for a $233.31 water bill payment. The receipt for this transaction included the suspect's [the AP's] name and address. The suspect was identified as the AP based on the receipts. The report further indicated that the police officer obtained receipts bearing the AP's name for various transactions where the debit card was used, along with camera footage from the stores where the transactions took place.

During an interview, the family member stated she received the resident's bank statement and noticed numerous charges she did not recognize. She said the resident typically only had charges from the assisted living and the pharmacy and that the resident did not go anywhere unless she took him. However, she bank statement showed charges from liquor stores and gas stations, so she reported this suspicious activity to the police. After reviewing surveillance footage from various stores around town, the police identified the AP as someone who worked at the facility where the resident lived. After the police informed her of the AP's name, she asked the resident if he remembered giving the AP the debit card, but the resident was unaware of any such action. The family member stated she found the debit card behind a bookshelf in the resident's room later.

During an interview, a manager stated she learned of the situation when she was informed a police officer had stopped by the facility looking for the AP. The manager then contacted the AP, who said the officer had asked her about some charges on a resident's debit card. The AP told the officer she did not know where the card was and denied touching the resident's wallet. The manager decided to have the on-call staff take over the AP's shift and suspended the AP pending the completion of the investigation. The manager stated that the AP's employment was terminated shortly thereafter.

During an interview, the AP stated she did not know the resident had a debit card although the police had questioned her. She said she thought the family managed all the resident's financial matters. She stated she was no longer employed at the facility.

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: … [omit section a unless there is a fiduciary element]
(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, due to cognitive decline
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility spoke with the AP and replaced her with on-call staff on the day they became aware of the incident. The AP was eventually terminated after the police confirmed that she had used the debit card.

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.

To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

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
Mille Lacs County Attorney
Isle City Attorney
Isle Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28438	A. BUILDING: _____ B. WING _____	C 11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING	540 EAST ISLE STREET ISLE, MN 56342

(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 On November 18, 2023, the Minnesota Department of Health initiated an investigation of complaint HL284386402M/HL284389548C. The following correction order is issued, 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. 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 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.	