Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307791202M, HL307791203M, HL307791204M and HL307791205M

Date Concluded: November 1, 2022

Compliance #: HL307792009C, HL307792010C, HL307792011C and HL307792012C

Name, Address, and County of Licensee Investigated:
York Gardens
3451 Parklawn Avenue
Edina, MN 55435
Hennepin County

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

Evaluator's Name: Lena Gangestad, 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 perpetrated (AP) financially exploited five residents when the AP stole $360 from resident #1, $20 from resident#2, $125 from resident #3, $50 from resident #4 and $300 from resident #5.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The alleged perpetrator (AP) was responsible for the maltreatment. The AP, who worked at the facility through a staffing agency, entered the residents' rooms and stole money.

The facility started an internal investigation and did not allow agency staff to be back in the building.

The investigator conducted interviews with facility employees including administrative and unlicensed staff member. The investigator contacted the family members of multiple residents. The investigation included contact with law enforcement. The investigation included a review of the residents' service agreement and internal investigation reports.

All five residents lived in the assisted living facility at the time of the incident.

Resident #1's diagnoses included hypertension and macular degeneration. The resident's service plan included assistance with dressing, bathing, laundry, and housekeeping.

Resident #2's diagnoses included peptic ulcer. The resident's service plan included assistance with bed making, laundry, and housekeeping.

Resident #3's diagnoses included anemia. The resident's service plan included assistance with medication administration, laundry, and housekeeping.

Resident #4's diagnoses included short-term memory loss.

Resident # 5's diagnosis included hardness of hearing.

During an interview, resident #1 stated the AP came into their apartment, and he observed she was new to the facility. The AP helped to dress resident #1 and his wife. The AP left but came back to help resident #1 and his wife get ready to go to lunch. The AP stated she forgot to make their bed, but resident #1 said he thought she had because the AP was in the bedroom for a while. Resident #1 stated he found his safe open and $360 missing the next morning.

During an interview, resident #1's daughter stated she had gone to the bank and took out the money for her parent. She put it in the white envelope and put it in the safe. When she learned the money was missing, she reported it to the facility.

During an interview, resident #2 stated AP had the key and opened the door. She asked resident #2 if he would like to have his bed made. He told the AP it was his wash day, so he had a new bed sheet out for her. Resident #2 stated $20 out in the dresser in his bedroom where AP was while he was in in the living room. Resident #2 stated he could hear noise like the AP was opening and closing her dresser drawers. Later, Resident #2 found AP did not change his bed and his $20 was gone.

During an interview, resident #3 stated $125 was taken from his billfold and he was not sure how it happened. He said a staff member came and cleaned the room. She wore a mask, so it was difficult to tell who it was. He said he felt safe, and this never happened before.

During an interview, the family member of resident #4 stated his mother passed away last month. The facility asked him to check his mother's room as part of the follow-up investigation. He stated he knew she had around $65 in her apartment. However, when he checked, she only had $15 left. He confirmed she had mild dementia, the facility had no store, and she could not drive.

During an interview, the unlicensed personnel (ULP) stated she worked for the facility for about 10 years. The ULP stated this was the first time she worked with the AP and the two of them worked on the same floor. The ULP confirmed seeing AP go to the resident's room when she was not supposed to as they were not part of her assignment, and she also noticed the AP carried her purse with her during work.

During an interview and email correspondence, the executive director (ED) stated he knew about the incidents because resident #1 reported it. He told ED his cash was missing from the safe. Throughout the day, a few more residents came out and reported similar situations. ED stated all the residents lost their money and resided on the same floor. He reported to the police and started an internal investigation. The ED stated reviewed the camera footage and care plan to see if it matched what the residents said. The ED stated he confirmed the AP entering the rooms of resident #3, #4, and #5 for which she had no reason to enter. The ED stated if the AP followed her schedule, there was no reason for her to enter these rooms. The ED stated the AP was mostly by herself and she wore her purse on her shoulder throughout the workday. The ED stated he spoke with the AP and the AP denied entering resident #3, #4, and #5. The ED confirmed there may have been one or two apartments AP entered alone, but most of them the residents were inside while it happened. The ED stated the AP would tell the resident she was there to do their laundry, which would allow her access to their bedroom. The ED stated some of the residents were immobile and would not be able to get into their bedrooms on time if they happened to be in their living rooms.

The investigation included attempt to reach the AP via phone calls and text. The investigator also sent a subpoena but with no response.

In conclusion, the Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment.

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: Yes
Alleged Perpetrator interviewed: No. Attempts to interview the AP were unsuccessful.

Action taken by facility:
The facility called the police and started an internal investigation. The ED called the agency and requested the AP is no longer allowed to enter the building.

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
Hennepin County Attorney
Edina City Attorney
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Nursing Assistant Registry

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30779	A. BUILDING: _____ B. WING _____	C 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK GARDENS SENIOR LIVING	3451 PARKLAWN AVENUE EDINA, MN 55435

(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: #HL307792009C/#HL307791202M #HL307792010C/#HL307791203M #HL307792011C/#HL307791204M #HL307792012C/#HL307791205M On September 28, 2022, 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 71 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL307792009C/#HL 307791202M, #HL307792010C/#HL 307791203M, #HL307792011C/#HL 307791204M and #HL307792012C/#HL 307791205M, tag identification 2360.	0 000	The Minnesota Department of Health documents 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	

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02360	Continued From page 1	02360		
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: Based on interviews, and document review, the facility failed to ensure five of five residents reviewed (R1, R2, R3, R4 and R5) was free from maltreatment. All five residents were financial exploited. Findings include: The Minnesota Department of Health (MDH) issued a determination that financial exploitation occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	