Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL334235142M
Compliance #: HL334236904C

Date Concluded: November 13, 2024

Name, Address, and County of Licensee Investigated:
Woodcrest of Country Manor
1200 Lanigan Way SW
Saint Joseph, MN 56374
Stearns County

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

Evaluator's Name: Michele Larson, 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), a facility staff member, financially exploited resident #1, resident #2, resident #3, resident #4, and resident #5, when the AP stole money, blank checks, a cell phone, and other personal items from the residents.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP stole money from resident #1, resident #2, resident #5 and an additional resident, resident #6. The AP stole blank checks from resident #3 in an attempt to steal money, a cell phone from resident #4, and bank account information for an additional resident, resident #7.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed residents' family members and law enforcement. The investigation included review of the residents' records, facility internal

investigation, facility incident reports, staff schedules, related facility policy and procedures, and the AP's personnel file.

Resident #1 resided in the assisted living facility and received no services. Resident #1 was alert and oriented to person, place, and time.

Resident #2 resided in the assisted living facility and received services. Resident #2's diagnoses included Parkinson's disease. Resident #2 was susceptible to abuse by others and was unable to manage her finances without family assistance. Resident #2 was alert and oriented to person, place, and time.

Resident #3 resided in the assisted living facility's memory care unit and received services. Resident #3's diagnoses included age-related physical debility. Resident #3 was susceptible to being abused by others and was unable to manage his finances without family assistance. Resident #3 was not oriented to person, place, or time.

Resident #4 resided in the assisted living facility's memory care unit and received services. Resident #4's diagnoses included dementia. Resident #4 was susceptible to being abuse by others and was unable to manage her finances without family assistance. Resident #4 was oriented to person only.

Resident #5 resided in the assisted living facility and received no services. Resident #5 managed her own finances.

Resident #6 resided in the assisted living facility side at the time of the alleged theft; moved into the facility's memory care unit shortly after the incident and received services. Resident #6's diagnoses included dementia. Resident #6's was susceptible to being abused by others and was unable to manage her finances without family assistance. Resident #6 was not oriented to person, place, or time.

Resident #7 resided in the in the assisted living facility and received services. Resident #7's diagnoses included dementia. Resident #7 was susceptible to abuse by others and was unable to manage her finances without family assistance. Resident #7 was not oriented to person, place, or time.

The facility's investigation indicated one day resident #4's family member reported resident #4's cell phone was missing along with resident #4's driver's license and other missing credit cards that resident #4 kept in the cell phone case. Facility staff assisted resident #4 and family in the search for the missing phone, driver's license, and credit cards without success. Fifteen days later, the AP stated he found resident #4's driver's license and credit cards in resident #4's drawer, but the cell phone was not found by facility staff.

The facility investigation indicated eleven days following the missing cell phone, resident #1 reported to leadership she was missing $60.00 cash. Resident #1 told leadership, resident #5 saw the AP leaving resident #1's apartment the same day resident #1 discovered the missing money. Resident #1 did not receive services from the assisted living so the AP should not have been in resident #1's apartment. Leadership talked with the AP who denied he was in resident #1's apartment but was in another apartment down the hall.

The facility investigation indicated three days later, resident #3 reported to leadership his checkbook was missing. Resident #3 could not recall the last time he saw his checkbook. Resident #3's family member stated she placed resident #3's checkbook inside his desk three weeks earlier after paying resident #3's bills. Leadership and resident #3's family member searched resident #3's apartment but they were unable to find the missing checkbook. Leadership found an additional checkbook inside resident #3's desk drawer. Leadership opened the checkbook and saw the last check was written by resident #3's family member three weeks ago and was numbered #5209 but the top blank check was numbered #5215, noting five checks were missing from resident #3's checkbook. Resident #3 was missing a checkbook and five additional blank checks. Resident #3's family member closed resident #3's bank accounts to prevent illicit activity.

The facility investigation indicated that same day in the morning., resident #5 called leadership regarding an incident that occurred in the facility hallway about three weeks earlier. Resident #5 stated she fell in the hallway, causing the contents of her purse to spill on the floor. The AP arrived and assisted resident #5 off the floor and picked up resident #5's belongings. As resident #5 turned and walked away she heard the AP yell, "found your wallet." The AP handed resident #5 her wallet. Resident #5 stated later that night she woke up feeling that "something was off" with her encounter with the AP. Resident #5 checked her wallet and noticed $20.00 was missing. When questioned by leadership, the AP denied he took the money from resident #5 and stated he was only trying to help resident #5.

The facility investigation indicated the following afternoon, leadership received a call from a staff member stating the AP used money from resident #3's bank account to buy a vehicle from the staff member's friends. The AP wrote the check from resident #3's bank account for $1000.00. The staff member told leadership the check used to purchase the car did not clear the bank due to the signature being illegible. After the purchase was denied at resident #3's bank, the staff member stated the AP transferred $1,350.00 from a Zelle application (used to transfer money between individuals from bank accounts) with resident #2's bank account information to pay for the car. The staff member sent screenshots to leadership identifying resident #2's name on the Zelle transaction for the purchase of the car. That same afternoon, leadership called law enforcement to report suspected theft in the facility. Police arrived at the facility and questioned the AP who was later arrested for theft and served a no trespassing order for the facility. When contacted, resident #2's family member confirmed $1,350.00 was taken out of resident #2's bank account one week earlier.

During an interview, the staff member stated one day she received a call from her friend stating the AP's check used to buy their car did not clear the bank. The staff member stated the next night at work she found out resident #3's checkbook was missing. The staff member asked her friends what name was on the AP's check, but the friends were unable to recall. The staff member asked her friends for a copy of the AP's check stating, "Something is going on. I wanted to make sure it's not what I think it is." The staff member stated her friends sent her an audio and video recording of the bank telling her friends resident #3's name was on the check the AP used to buy the car. The staff member stated she immediately reported the incident to leadership and sent the recording. The staff member stated later that day her friend called her asking if she knew resident #2 because the AP sent them $1,350.00 (the amount of the vehicle) through the Zelle cash app with resident #2's name and information. The staff member's friend sent her a screenshot of the Zelle transaction with resident #2's information which she forwarded to leadership.

During an interview, leadership stated they immediately called law enforcement when they confirmed the AP was the person responsible for resident #2 and resident #3's stolen money and checks. Leadership stated the AP tried to "bolt" out of their conference room when questioned by law enforcement. The AP initially told law enforcement he did not have his cell phone with him, but law enforcement later found it in his work fanny pack when arresting the AP. Leadership stated following the AP's arrest, the AP's family member came to the facility to retrieve the AP's backpack which was left behind in an office used by staff. Upon unzipping the backpack leadership saw resident #3's extra missing checkbook laying on top of the AP's belongings. Leadership stated, "It was heart wrenching because I have to trust our staff that they are here for the right reasons and unfortunately, the AP was here for the wrong reasons."

The law enforcement investigation indicated they obtained a search warrant for the AP's cell phone and discovered pictures of resident #6 and resident #7's debit card. The AP had used resident #6's debit card information to take out $200.00 from resident #6's bank account. In addition, the AP's phone contained approximately 93 to 95 additional pictures of other individuals credit card information. Law enforcement continued the investigation to determine if any of the credit card information belonged to additional residents at the facility. The investigation remained on-going and had been forwarded to the county attorney for charges.

When interviewed, resident #3's family member stated resident #3 knew his bank account balances and was able to sign his own checks. The family member stated one week before his checkbook went missing resident #3 called her stating someone stole his favorite bottle of cologne. The family member stated the AP confessed he accidentally "broke" resident #3's cologne and apologized for breaking the bottle. The family member stated at the time she thought it was odd there was no glass on resident #3's bathroom floor or the strong smell of cologne that would have been smelled. The family member stated one week later, resident #3 called her to report someone stole his checkbook. The next morning resident #3 called the bank to freeze his account. The family member stated she looked in resident #3's second checkbook and saw five checks were missing stating she immediately went to that bank and froze his

account. The family member stated after the AP was arrested, law enforcement asked for resident #3's signature on a blank piece of paper to compare it with the resident #3's check the AP used to buy the car. The family member stated law enforcement then asked her to identify resident #3's check for $1000.00 the AP used to buy the car. The family member stated the signature on resident #3's check did not match resident #3's signature.

When interviewed, resident #4's family member stated resident #4 was unable to recall anything. The family member stated resident #4 never took her cell phone out of her apartment. The resident's family member stated the AP "found" resident #4's insurance cards and expired Visa card after it "magically" appeared about one month after they went missing. The family member stated the AP contradicted himself on where he found resident #4's items, stating at first, he found them on the floor but then later said he found the items mixed in with papers. The family member stated, "it didn't sound very believable." The family member stated there have been no further incidents of theft since the AP was arrested and terminated.

When interviewed, resident #6's family member stated resident #6 initially resided in the assisted living side but moved into the facility's memory care unit shortly after the incident. Resident #6's family member stated one day she noticed a $200.00 charge through a mobile payment app (Venmo) as she was going through resident #6's finances. The family member stated resident #6 rarely used her debit card. The family member stated she immediately called resident #6's bank, stating the bank credited the $200 back to resident #6's bank account two days later. The family member stated at the time she never told facility leadership because she did not make the connection until law enforcement called to inform her they arrested the AP and confiscated his cell phone where they discovered a photo of resident #6's debit card in the AP's cell phone.

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: The investigator attempted to contact resident #1, resident #5, and resident #7 without success.

Family/Responsible Party interviewed: Yes. Resident #3, resident #4, and resident #6's family members were interviewed. Resident #2's family member declined to be interviewed.

Alleged Perpetrator interviewed: No, according to law enforcement request.

Action taken by facility:
The facility immediately called law enforcement upon learning about the residents stolen money and items.

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
Stearns County Attorney
St. Joseph City Attorney
St. Joseph Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33423	A. BUILDING: _____ B. WING _____	C 09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST OF COUNTRY MANOR	1200 LANIGAN WAY SW SAINT JOSEPH, MN 56374

(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****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order is 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: #HL334236904C/#HL334235142M On September 18, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 96 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL334236904C/#HL334235142M, 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.	
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.	02360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33423	A. BUILDING: _____ B. WING _____	C 09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST OF COUNTRY MANOR	1200 LANIGAN WAY SW SAINT JOSEPH, MN 56374

(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
02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure seven of seven residents reviewed (R1, R2, R3, R4, R5, R6, R7) were 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 required.	