Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL34712001M
Compliance #: HL34712002C

Date Concluded: January 28, 2022

Name, Address, and County of Licensee Investigated:
Millers Landing Senior Living
155 5th Avenue South
Minneapolis, MN 55401
Hennepin County

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

Evaluator's Name: John Sheridan-Giese, 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.

Allegation(s):

It is alleged: the AP financially exploited the resident when he purchased the resident's automobile and did not pay the resident.

It is alleged: The alleged perpetrator (AP) sexually abused the resident when he engaged in a sexual relationship with the resident.

Investigative Findings and Conclusion:
Financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP financially exploited the resident when he purchased the resident's automobile below market value, did not pay the resident the agreed upon amount, and took the resident's vehicle and vehicle title into his possession.

It was inconclusive as to whether sexual abuse occurred. The AP denied having a sexual relationship with the resident while the resident declined to discuss the topic.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included a review of the resident's medical record. The investigation included a review of the AP's personnel record.

The resident's diagnoses included borderline personality disorder, depression, general anxiety disorder, alcohol dependence, and polysubstance abuse. The resident's service plan indicated the resident required assistance of female staff only, as the resident made impulsive decisions. The resident's service plan indicated the resident required hourly safety checks for suicidal ideation. The resident's service plan indicated the resident required behavior management, and staff was to document, and monitor the resident's reactive behaviors in a supportive environment.

A notarized purchase agreement between the resident and the AP indicated the resident sold her car to the AP. The purchase agreement indicated the vehicle was in the AP's possession, and the vehicle's title was to be transferred to the AP after the AP made all of the agreed upon payments.

A review of the AP's personnel record indicated the AP was employed by the facility at the time the purchase agreement was signed. The AP's personnel record indicated the AP was trained in abuse prevention, caring for vulnerable adults, resident rights, and home care bill of rights. The AP's personnel record indicated the AP was a "no call no show" for work which ended his employment at the facility.

A comparison of the date of the purchase agreement and the date of AP's "no call no show", indicated the AP did not show up for work and his employment ended with the facility the day after he signed the purchase agreement.

The resident's medical record indicated the resident sold her automobile to the AP for $3,000 but the AP only paid $2000 of the agreed amount and took the car's title from the resident. The resident's medical record indicated there was an allegation of a sexual relationship between the resident and the AP. The resident's medical record indicated the AP paid $2,000 to the resident and then took the automobile's title from the resident.

A review of the Kelly Blue Book, a consumer and automotive industry vehicle valuation, indicated the resident's car was valued between $4,085 and $6,214. A review of the Kelly Blue Book also indicated similar vehicles with similar mileage and condition, as the resident's vehicle, were valued within the same range.

During an interview, the resident stated she received $2,000 from the AP, but the AP still owed her $1,000 for the vehicle. The resident stated the AP came into her apartment multiple times,

and they “hung out” together. The resident stated the AP took the title of the vehicle from her apartment, without her permission. The resident stated she did not feel comfortable answering questions about the nature of her and the AP’s relationship.

During an interview, the dietary manager (DM) stated she supervised the AP, and the AP was aware male staff was not allowed in the resident’s room and food was to be delivered outside of the resident’s room. The DM stated the AP asked her several times why male staff was not allowed in the resident’s room.

During an interview, the AP stated he would drive the resident’s vehicle and take the resident to the liquor store. The AP stated he was aware males were not allowed in the resident’s room, and other staff had told the AP not to bring food in the resident’s room, and to not interact with the resident. The AP stated he and the resident drank alcohol together in the resident’s apartment, and the AP was aware of the resident’s drug and alcohol dependency issues. The AP stated the resident wanted to sell him the resident’s vehicle. The AP stated after he paid the resident $2,000, the resident gave him the title to the vehicle. The AP stated he owed the resident $1,000 and did not pay the resident due to family issues. The AP stated he was gainfully employed, did not contact the resident to settle payment, and the vehicle continued to be in the AP’s possession. The AP stated he would engage in similar business dealings in the future, if given the opportunity. The AP stated he and the resident did not have a sexual relationship.

In conclusion, financial exploitation was substantiated while it is inconclusive whether sexual abuse occurred.

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.

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.
"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.

(c) Nothing in this definition requires a facility or caregiver to provide financial management or supervise financial management for a vulnerable adult except as otherwise required by law.

Abuse: Minnesota Statutes section 626.5572, subdivision 2
"Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.

(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: The AP is no longer employed by the facility.

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
Minneapolis City Attorney
Minneapolis Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34712	A. BUILDING: _____ B. WING _____	C 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLERS LANDING SENIOR LIVING	155 5TH AVENUE SOUTH MINNEAPOLIS, MN 55401

(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., the Minnesota Department of Health issued a correction order(s) pursuant to an evaluation. 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: On December 1, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL34712002C/#HL34712001M. At the time of the evaluation, there were #34 residents receiving services under the assisted living license. The following correction order is issued for #HL34712002C/#HL34712001M, 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 home care provider 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.	
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: Based on observations, interviews, and document review, the facility failed to ensure one of two residents reviewed (R1) was free from maltreatment. R1 was financially exploited. Findings include: On January 28, 2022, 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. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	