Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL240626703M
Compliance #: HL240626082C

Date Concluded: February 11, 2026

Name, Address, and County of Licensee Investigated:
Presbyterian Homes of Bloomington
9889 Penn Avenue South
Bloomington, MN 55431
Hennepin County

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

Evaluator's Name: Holly German, 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 residents (resident 1, resident 2, resident 3, resident 4, resident 5, resident 6, resident 7, resident 8) when she took resident debit cards, credit cards, and cash to make personal purchases with them.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment of resident 1, resident 2, resident 4, resident 5, resident 6, and resident 7. The AP admitted she stole resident credit and debit cards, and made fraudulent charges to the accounts of resident 1, resident 2, resident 4, resident 5, resident 6, and resident 7, to law enforcement. Resident 3's missing cash and check were found in her room approximately two weeks after they were reported missing. Law enforcement determined the fraudulent activity to the saving's account of resident 8 were a result of identity theft of another person in another state and was not related to the fraudulent activity that occurred at the facility.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted law enforcement. The investigation included review of resident records, resident financial records, facility internal investigations, facility incident reports, personnel files, staff schedules, law enforcement reports, and related facility policy and procedures.

Resident 1

Resident 1 resided in an assisted living facility. The resident's diagnoses included type two diabetes, chronic heart failure, and difficulty walking. The resident's service plan included assistance with toileting, laundry, and bathing. The resident's assessment indicated the resident was alert, oriented, used a walker for walking, and was independent with her finances.

A facility internal investigation document indicated resident 1 notified facility staff her debit card was missing. The following day, facility staff assisted resident 1 by calling her bank, reviewed surveillance video footage, contacted law enforcement, and placed the AP on administrative leave. The document indicated law enforcement notified the facility the AP admitted to taking resident 1's debit card to the law enforcement officer during an interview with the AP. The document indicated $3,838.39 was fraudulently charged to resident 1's debit card.

Resident 1's debit card statement indicated 17 fraudulent charges were placed on resident 1's account, three of which were in person attempts at a local coffee shop and store. The remaining attempts were online purchases.

The facility staff schedule indicated the AP was scheduled to work from 3:30 p.m. to 10:00 p.m. and was not assigned to resident 1's care on the day resident 1's debit card was noted to be missing by resident 1.

Facility video surveillance footage showed the AP entering resident 1's room, and exiting two minutes later on the day resident 1 noted her debit card missing.

An email from the law enforcement detective to the facility, included photos of the AP at the store on the date and at the time a fraudulent charge was placed to resident 1's debit card from the same store.

Facility notes from an investigative interview with the AP indicated the AP stated she entered resident 1's room to answer resident 1's call light. The AP stated she assisted resident 1 to pull up her pants in the bathroom and left. The AP stated she did not see anything laying out in resident 1's apartment and asked if any other staff were being questioned about resident 1's missing debit card. The same document, dated six days later, indicated a second interview was completed by facility staff with the AP. The AP was questioned about the date she was noted on camera at the store while she was scheduled to be on shift at the facility. The document

indicated the AP stated she went to her car to eat and take her break, but staff had noted her to be gone for 45 minutes. The document indicated the AP stated she had left the facility and went to the store to get medicine for herself. The document indicated facility staff had record the AP left the facility and returned to the building 45 minutes later. The document indicated it took seven minutes to drive back to the facility from the store.

An email received from law enforcement indicated the AP admitted to taking and using resident 1's card during two interviews completed by law enforcement.

Resident 2

Resident 2 resided in an assisted living facility. The resident's diagnoses included dementia and bone cancer. The resident's service plan included assistance with medication administration, laundry, grooming and bathing. The resident's assessment indicated the resident used a walker for walking, had severe cognitive impairment, and had a family member manage her finances.

A facility internal investigation document indicated the facility was notified resident 2's credit card was missing, and law enforcement was contacted. The document indicated 31 known fraudulent charges to resident 2's account that totaled $571.19 at the time the incident was reported. The document indicated the fraudulent charges started one month earlier.

The facility staff schedule indicated the AP was scheduled to work at the facility and assigned to care for resident 2 the day fraudulent charges started on resident 2's credit card.

An email received from law enforcement indicated the AP admitted to taking and using resident 2's card during two interviews completed by law enforcement.

Resident 3

Resident 3 resided in an assisted living facility. The resident's diagnoses included hypertension, osteoporosis, and anemia. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident was independent with activities of daily living, alert, oriented, and made her own financial decisions.

A facility internal investigation document indicated resident 3's family notified the facility that resident 3 was missing $400 in cash and a check written out to resident 3 for $600. The document indicated the cash and check were found in resident 2's room two weeks later.

Resident 4

Resident 4 resided in an assisted living facility. The resident's diagnoses included atrial fibrillation, physical debility and history of falls. The resident's service plan included assistance with homemaking, medication administration, and bathing. The resident's assessment indicated the resident was independent walking with a walker, was alert and oriented, and had a family member manage his finances.

A facility internal investigation document indicated resident 4's family member notified the facility of fraudulent charges to resident 4's debit card and credit card accounts, that occurred approximately two months prior.

Resident 4's bank statement indicated 10 fraudulent transactions on resident 4's bank account that totaled $551.61.

The facility staff schedule indicated the AP worked at the facility the day the fraudulent charges started on resident 4's bank account.

Resident 4's service delivery record indicated the AP assisted resident 4 with his shower the day before fraudulent charges started on his bank account.

An email received from law enforcement indicated the AP admitted to taking and using resident 4's cards during two interviews completed by law enforcement.

Resident 5

Resident 5 resided in an assisted living facility. The resident's diagnoses included cirrhosis of the liver and edema. The resident's service plan included daily assistance with his leg wraps. The resident's assessment indicated the resident was independent with activities of daily living, was alert and oriented, and managed his own finances with help from a family member.

A facility internal investigation document indicated resident 5 notified facility staff his credit card and wedding ring were missing for four to five days. The document indicated there was $1000.00 of known fraudulent charges to resident 5's credit card.

The facility staff schedule indicated the AP was assigned to care for resident 5 for two shifts during the time frame resident 5 stated his credit card and wedding ring went missing.

An email received from law enforcement indicated the AP admitted to taking and using resident 5's card during two interviews completed by law enforcement.

Resident 6

Resident 6 resided in an assisted living facility. The resident's diagnoses included atrial fibrillation, anemia, and anxiety. The resident's service plan included assistance with incontinence care, homemaking, bathing, and transfers. The resident's assessment indicated the resident was alert and oriented, used a wheelchair independently, and managed her own finances.

A facility internal investigation document indicated resident 6 notified facility staff her credit card was missing. The document indicated there were seven fraudulent charges between two of resident 6's credit cards that totaled $2,238.82 and took place approximately two months prior.

The facility staff schedule indicated the AP was assigned as resident 6's caregiver for nine shifts prior to the start of fraudulent charges to resident 6's credit cards.

An email received from law enforcement indicated the AP admitted to taking and using resident 6's card during two interviews completed by law enforcement.

Resident 7

Resident 7 resided in an assisted living facility. The resident's diagnoses included heart failure, hypertension and edema. The resident's service plan included assistance with bathing and application of leg wraps. The resident's assessment indicated the resident was alert and oriented, walked with either a cane or walker, and had family members who assisted with the management of his finances.

A facility internal investigation document indicated resident 7's family member notified facility staff resident 7's debit card and credit card were missing and had fraudulent charges. The document indicated there were three fraudulent charges that occurred approximately one and a half months earlier and totaled $1738.78 on resident 7's credit card and $29.71 on resident 7's debit card.

The facility staff schedule indicated the AP was assigned as resident 7's caregiver for 11 shifts prior to the day fraudulent charges started on resident 7's debit and credit cards.

Resident 7's service delivery record indicated the AP assisted resident 7 with bathing two times during the month, one of which included on the day the fraudulent charges started.

An email received from law enforcement indicated the AP admitted to taking and using resident 7's cards during two interviews completed by law enforcement.

Resident 8

Resident 8 resided in an assisted living facility. The resident's diagnoses included chronic heart failure, anemia, and lymphedema. The resident's service plan included assistance with bathing. The resident's assessment indicated the resident walked with a walker, was alert and oriented, and had a family member manage her finances.

A facility internal investigation document indicated resident 8's family member notified facility staff resident 8's account had large sums of money withdrawn from it, and fraudulent credit card charges that occurred approximately one month earlier. The document indicated a total of $10,336.59 of fraudulent credit card charges, and eight electronic withdrawals that totaled $128,250.00 transferred out of resident 8's money market account and to another account at a different bank.

The facility staff schedule indicated the AP was not assigned as resident 8's caregiver before or during the time frame when the fraudulent charges took place on resident 8's accounts.

An email from law enforcement indicated the fraudulent transfers out of resident 8's bank account was not related to the other incidents or staff at the facility and was determined to be an identity theft case that involved another victim in a different state.

During an interview, ULP-2 stated she received training on abuse, neglect, and financial exploitation of vulnerable adults from the facility. ULP-2 stated there were three residents who spoke to her about the fraudulent charges to their accounts. ULP-2 stated one day resident 6 appeared upset, and when she asked her what was wrong, resident 6 stated a caregiver had stolen money from her, the caregiver was fired and would not be returning to the facility. ULP-2 stated resident 1 told her a caregiver came into her room and stole her credit card, but the facility was taking care of it. ULP-2 stated resident 7 told her a caregiver had stolen money from him but did not say who he thought it was. ULP-2 stated there was a time the AP told her she had tried to order clothing online, but the website was not allowing her to order more. The AP believed it was due to her making multiple returns. ULP-2 stated she noticed the AP would sometimes have food orders delivered to the facility via door dash service, but the AP mostly did food take out orders that she went and picked up. ULP-2 stated the AP had a lot of coffee (from the coffee shop associated with the fraud) while at work. ULP-2 stated the last day the AP worked at the facility, the AP asked ULP-2 if she could go to the store (same store associated with the fraud) on her break time because she did not feel good and needed to get medicine. ULP-2 stated the AP took over an hour to return and told ULP-2 she left her medicine in her car. ULP-2 stated it was abnormal for the AP to take that long of a break, as she normally went out and came right back.

During an interview, the licensed assisted living director (LALD) stated she was notified via an email from the receptionist resident 1 reported her debit card was missing. The LALD stated she met with resident 1 to ask her where she last saw it, what she last used it for, and the timeline of when she noticed it was missing. The LALD stated she assisted resident 1 with calling her bank to report the missing card, and to see if the card had been used since it went missing. The LALD stated resident 1 told her she noted her debit card to be missing after she had pressed her call button for help and a caregiver who was not her regular caregiver came in to help her. The LALD stated resident 1 told her she felt something was off with that caregiver and identified the caregiver as the AP. The LALD stated she was also involved in the investigations of the fraudulent charges to the other resident's accounts. She stated the facility contacted law enforcement and made reports. The LALD stated there have not been any additional fraudulent charges reported since the AP's employment was terminated from the facility. The LALD stated all the resident cases were very similar in charges.

During an interview, a family member of resident 2 stated resident 2 did not participate in anything regarding her money or finances due to her dementia, but did have a purse with a wallet that contained cash and cards kept in her room. The family member stated since the theft occurred, resident 2 no longer kept any cash or cards in her purse. The family member stated neither she nor resident 2 had any concerns about staff prior to the thefts. The family

member stated she became aware of fraudulent charges to resident 2's accounts when her brother called her and asked if she had used their mother's card for coffee or at the store. The family member stated she had not used resident 2's cards for anything, so she went to see resident 2 two days later and could not find her card. The family member stated she reported the concern to facility staff who called police. The family member stated since the theft was reported, there had been no further fraudulent charges, and she believed the facility handled the situation appropriately.

During an interview, a family member of resident 4 stated resident 4 did not handle his finances due to short term memory loss but had carried a credit card and debit card in his wallet prior to the fraudulent charges to his accounts. The family member stated resident 4 kept his wallet on his nightstand next to his bed when it was not on him. The family member stated the cards never went missing, but he noticed transactions to resident 4's accounts that he did not make. The family member stated he contacted resident 4's bank to report it and resident 4 received replacement cards. The family member stated a week or two later, the new cards had also been compromised. The family member stated he then received a notice from the facility of fraudulent charges that occurred to resident accounts, so he reported to the facility the charges that had occurred to resident 4's accounts. The family member stated resident 4 did not know how the charges could have occurred since he kept the cards on him, but the family member stated he did not have the cards on him when he was sleeping, getting dressed, or showering. The family member stated the incident was confusing and stressful to the resident.

During an interview, a family member of resident 7 stated resident 7 has access to his financial accounts, but another family member handled most of it as his power of attorney. The family member stated resident 7's bank cards were in his wallet that was kept in a drawer under socks in his room. The family member stated he had looked at an account statement and noticed a charge from door dash on the account and he knew that was not something resident 7 would do. The family member stated he spoke to the other family member about it, and an additional fraudulent charge appeared two days later. The family member stated resident 7 did not know how it could have happened as the cards never went missing. The family member stated he explained to resident 7 someone must have gone through his drawer and took pictures of his cards. The family member stated resident 7's financial institutions were contacted, and those cards were cancelled. The family member stated new cards were received and there had not been any fraudulent charges to the new cards. The family member stated he was very pleased with how the facility handled the situation and was very satisfied with the services provided to resident 7.

During an interview, a family member of resident 8 stated resident 8 was not involved with her finances. The family member stated resident 8 had a card in her possession in her apartment, and she watched the activity of the checking account since the only thing that came out of it was her rent payment to the facility. The family member stated she noticed there was only $7,000 in the account when there should have been around $100,000, so she went right to the bank and called the fraud department. The family member stated she realized she had

previously received an email from the facility about fraud happening at the facility, but she did not pay much attention to it at the time. The family member stated she then reported to the facility all the money was gone in resident 8's account, and charges to resident 8's credit card. The family member stated the police were called and the timing of resident 8's missing money was in the same time frame of the fraudulent incidents with other residents at the facility. The family member stated she did not ask resident 8 about it because she did not believe that would have been good for resident 8 to know. The family member stated there was a previous incident where resident 8's mother's ring was stolen and never found. The family member stated there had not been any additional concerns for resident 8's accounts since the reported incident.

The AP failed to return a subpoenaed request for interview.

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:
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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was a sudden event.

Vulnerable Adult interviewed: No, due to trauma for some residents and cognition for some.
Family/Responsible Party interviewed: Yes; family of residents 2, 4, 7 and 8. No; family of residents 1, 3, 5, and 6 did not respond.
Alleged Perpetrator interviewed: No; did not respond to requests or subpoena.

Action taken by facility:
The facility investigated and reported the thefts to law enforcement. 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.

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
Hennepin County Attorney
Bloomington City Attorney
Bloomington Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24062	A. BUILDING: _____ B. WING _____	C 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRES HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431

(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, 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: HL240626703M/HL240626082C On December 15, 2025, 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 93 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL240626703M/HL240626082C, 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
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: The facility failed to ensure six of eight resident(s) reviewed (R1, R2, 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	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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31	

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02360	Continued From page 2	02360	SUBDIVISION 1-3.	