DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL240773083M
Compliance #: HL240771785C

Date Concluded: June 23, 2026

Name, Address, and County of Licensee Investigated:
Summerwood of Chanhassen
525 Lake Drive
Chanhassen, MN 55317
Carver County

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

Evaluator's Name: Brandon Martfeld, RN, BSN, 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 the resident when the AP stole the resident's debit card and made purchases that totaled over $3,000 dollars.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP obtained the resident's debit card and made purchases that totaled over $3,000 dollars. The AP had a prior history of debit card theft that totaled over $16,000 dollars.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, facility employee handbook, and law enforcement report. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included anxiety disorder, major depression disorder, and mild cognitive impairment. The resident's service plan included assistance with medication administration, showers and escort assistances to and from destinations. The resident's assessment indicated the resident was alert but confused, had a family member assist with financial matters, and had difficulty navigating and finding her apartment due to cognitive impairment.

Law enforcement reports indicated the resident's debit card was obtained and used by the AP at numerous locations. Over the course of seven days, the AP spent over $3,000 dollars.

The first day, the AP used the debit card four times, once at a tobacco store for $9.70, a second time at a gas station for $109.90, a third time at a retail store for $200.00 and a fourth time at a restaurant for $74.05.

The second day, the AP used the debit card three times, once at a gas station for $113.03, a second time at a retail store for $197.77, and a third time at a restaurant for $89.08. On the third day, the AP used the debit card once at gas station for $119.45.

The fourth day the AP used the debit card eight times. Once at a retail store for $163, then a second time at a sports store for $163.00, a third time at a restaurant for $16.89, a fourth time at a gas station for $32.38, a fifth time at a retail store for $53.99, a sixth time at a restaurant for $16.35, a seventh time at a restaurant for $10.66, and an eighth time at a gas station for $126.66.

The fifth day, the AP used the debit card five times, once at a gas station for $121.66, a second time at a gas station for $176.63, a third time at a restaurant for $16.89, a fourth time at a retail store for $59.99 and a fifth time at a restaurant for $75.93.

The sixth day, the AP used the debit card twice, once at a gas station for $213.46 and a second time at a gas station for $260.98.

The seventh day, the AP used the debit card five times, once at a gas station for $165.72, a second time at a retail store for $343.20, a third time at a retail store for $62.81, a fourth time at a restaurant for $62.81, and fifth time at a gas station for $11.08.

The law enforcement report included photos of the AP using the debit card at various locations and photos of the AP dressed in her facility work uniform where the resident resided. The law enforcement report indicated the AP admitted to using the debit card and law enforcement was pressing charges against the AP. The law enforcement report indicated the AP had debit card fraud filed against her approximately four years ago and that the total amount exceeded $16,000 dollars.

During an interview, the AP stated she had been working in healthcare for over 10 years and used the debit card because she was going through a hard time. She saw it as a way to make her situation better. The AP stated she used the debit card at a retail store and other various stores.

During an interview, facility leadership stated the AP was identified from photos that law enforcement supplied and by reviewing the facility's camera footage. The camera footage showed the AP going into the resident's room. The debit card was used in the area of the AP's address on file with the facility. Facility leadership stated the AP was no longer employed by the facility.

During an interview, a family member stated the resident's debit card was kept in the resident's drawer and had not been used in almost a year. When she was reviewing the resident's bank account, she noticed charges were made with the resident's debit card. The stores the charges were incurred were not stores the resident would use the debit card at and the resident could not get to those stores without assistance.

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:
(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. Per the request of the family member.

Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation. The AP is no longer employed at 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
Carver County Attorney
Chanhassen City Attorney
Carver County Sheriff Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24077	A. BUILDING: ______ B. WING ______	C 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERWOOD OF CHANHASSEN	525 LAKE DRIVE CHANHASSEN, MN 55317

(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: #HL240773083M / #HL240771785C On June 15, 2026, 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 77 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL240773083M / #HL240771785C, tag identification 2360.	0 000	Assisted Living Provider 144G. 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.	

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERWOOD OF CHANHASSEN	**525 LAKE DRIVE CHANHASSEN, MN 55317**

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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: The facility failed to ensure one of one resident (R1) reviewed was 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		