Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL297196422M
Compliance #: HL297195162C

Date Concluded: January 8, 2026

Name, Address, and County of Licensee Investigated:
Valora Senior Living of St. Anthony
2540 Kenzie Terrace
St. Anthony, MN 55418
Hennepin County

Facility Type: Assisted Living Facility (ALF)

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) financially exploited resident #1, and resident #2 when the AP accepted money as a gift from resident #1 and became a beneficiary (an individual or entity designated to receive benefits) of resident #2's retirement bank account.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP acquired shared possession of resident #2's retirement account when he became a beneficiary on the account. When resident #2 passed away, the AP designated to receive $110,000 dollars from resident #2's retirement account. In addition, the AP received cash from resident #1 monthly for an unknown total amount, but more that $500.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of both resident #1 and

resident #2 records, resident #2's death record, facility internal investigation, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator made an unannounced visit to the facility.

Resident #1 resided in an assisted living facility. Resident #1's diagnoses included stroke and weakness. Resident #1's service plan included assistance with bathing, grooming, toileting, transfers, and medication administration. Resident #1's assessment indicated resident #1 had intact cognition, managed his finances independently and required staff to assist with activities of daily living because of impaired mobility. Resident #1's individual abuse prevention plan (IAPP) indicated the resident was able to recall events and provide accurate information.

Resident #2 resided in an assisted living facility. Resident #2's diagnoses included diabetes and Parkinson's disease. Resident #2's service plan included assistance with bathing, grooming, toileting, dressing, and medication administration. Resident #2's assessment indicated resident #2 had intact cognition, managed his finances independently and received hospice services. Resident #2's IAPP indicated the resident was able to recall events and provide accurate information.

The facility investigation indicated a family member of resident #2 reported the AP was a 10 percent beneficiary to resident #2's retirement account. The family member had learned when resident #2 passed away that the AP received money from the retirement account. During the facility investigation, other residents were interviewed and resident #1 stated he provided the AP with $50 to $100 dollars a month and at one point gave the AP $500 dollars to ship clothes to a different country. When leadership interviewed the AP, the AP stated he was aware of the facility policy on accepting gifts or handling resident money. The AP denied being the beneficiary of resident #2 and denied accepting money or gifts from residents.

Resident #2's retirement account document listed the AP as a 10 percent beneficiary.

During an interview, resident #2's family member stated about three or four months prior to resident #2 passing away, the AP was added to the resident's retirement account. The AP would receive about $110,000 dollars when resident #2 passed away. Resident #2 told the family member the AP was poor and did not have a lot of money. Resident #2 felt sorry for the AP. The family member stated the AP made resident #2 feel sorry for him and benefitted financially from resident #2. The family member stated the AP's lawyer called him requesting a copy of resident #2's death certificate to acquire money from the account.

During an interview, the financial institution representative of resident #2's retirement account stated the AP had not withdrawn the money from the account at the time, but confirmed the AP was a beneficiary. The representative stated they were concerned regarding the investigation about fraud.

During an interview, resident #1 stated he gave the AP money every month. Resident #1 stated he was unsure for how many months or the total of how much money he gave the AP. It was never less than $50 dollars a month. Resident #1 stated he gave the AP $500 dollars one month so that he could ship clothes to another country.

During an interview, facility leadership stated prior to the incident, the AP was educated on the facility's handbook, which indicated gifts and cash are not to be accepted by employees. The facility became aware of the incident when resident #2's family member notified them of the AP being a beneficiary of resident #2's retirement account. After being notified by the family member, the AP was suspended. It was determined that the AP also received an unknown amount cash from resident #1. Following the incident, the AP was interviewed and stated he was aware that gifts and cash were not to be accepted by employees and denied taking or accepting gifts or cash from residents.

The AP did not respond to the multiple requests for an 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: … [omit section a unless there is a fiduciary element]
(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.

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 not a sudden or foreseen event.

Vulnerable Adult interviewed: Resident #1 was interviewed. Resident #2 was deceased.
Family/Responsible Party interviewed: No for resident #1, who was responsible for himself.
Yes, for resident #2.
Alleged Perpetrator interviewed: No. Did not respond to subpoena.

Action taken by facility:
During the investigation, the facility suspended the AP and is no longer employed by the facility. Staff were given education about financial exploitation and accepting money/gifts from residents. 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
St. Anthony City Attorney
St. Anthony Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29719	A. BUILDING: _____ B. WING _____	C 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALORA SENIOR LIVING ST. ANTHONY	2540 KENZIE TERRACE SAINT ANTHONY, MN 55418

(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: HL297196422M/HL297195162C On December 9, 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 48 residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL297196422M/HL297195162C, 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 two of two residents reviewed (R1 and R2) 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		