Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL327586363M
Compliance #: HL327585064C

Date Concluded: February 5, 2026

Name, Address, and County of Licensee Investigated:
Wellness Homes Inc.
6748 101st Street South
Cottage Grove, MN 55016
Washington County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Willette Shafer, RN
Special Investigator

Finding: Inconclusive

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 the resident when the AP told the resident to sign an unknown form while at the bank and the resident later discovered $3,861 was removed from his bank account without his knowledge.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was inconclusive. The AP denied the allegation and stated she only assisted with driving the resident to his bank so he could withdraw money. The social worker reported the resident was upset when he returned from the bank and said while at the bank, he signed an unknown form, and all his money was removed from his bank account. The money was removed in the form of a cashier's check within the resident's name. The check was later given to a community member by the AP with the resident's reluctant approval. It was unclear if the resident allowed the community member to have the check under duress as the AP and community members spoke to the resident in another language. The resident declined to interview about the incident afterwards.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigator interviewed a family member and contacted the resident's financial institution. The investigation included review of the resident's record and financial statements.

The resident resided in an assisted living facility. The residents' diagnoses included diabetes. The resident's service plan included assistance with medication management, toileting, grooming, bathing, meals, laundry, and housekeeping. The resident's assessment indicated he made his own decisions but was forgetful and had poor decision making.

The resident's bank statements indicated a cashier's check for $11,000 was written out in the resident's name. Three days later, a second cashier's check for $600 was written out with the resident as the payee.

The resident's discharge summary dated three days after the second cashier's check, indicated the resident was discharged to the hospital and for a higher level of care.

Approximately two weeks later, the resident discharged from the hospital and admitted to a nursing home. The resident had remained at the nursing home at the time of the investigation.

During an interview, the resident's social worker said the AP took the resident to the bank. When they returned the resident reported he signed an unknown form at the bank and all his money was removed from his bank account. The AP gave several different "excuses" about what happened at the bank but none of them made sense. The social worker called the bank with the resident present, and the bank confirmed $3,800 was removed from the resident's account in the form of a cashier's check. The AP was told to bring the cashier's check to the social worker, and she was not supposed to see the resident as the resident said he did not want to see the AP. A few days later the AP and two unknown men, one a "community leader" and the second said he was related to the resident, but gave several different types of relations (brother, cousin, uncle), came to the facility. They went to the residents' room despite being instructed not to visit the resident. They had a five-minute conversation with the resident in a foreign language and then the resident said the "community leader" could hold on to the cashier's check. The community leader visited the resident once after this interaction and then the resident reported he no longer wanted the community leader to visit him. The resident was supposed to be discharged back to the facility, but the resident reported he wanted nothing to do with the AP anymore.

The resident's bank statements indicated on the date of the incident (nine months after the resident discharged from the assisted living) a cashier's check was written for $3,851.34 with the resident's name as the payee. Also, $40 dollars was withdrawn from the automated teller machine (ATM).

During an interview, the AP said the resident admitted to the facility in 2020. The AP said she brought the resident to the bank because he wanted to withdraw money. The next day she received a call asking what happened to the resident's money. She said the resident was confused and forgetful. She brought the cashier's check back to the resident and the resident gave it to a "family friend." When asked why she confronted the resident with two other men about the check she said those two other men happened to show up at the same time she brought the check to the resident. When asked why she went to the resident's room instead of giving the check to the social worker she said she was never told she could not see the resident. She said she was unaware of where the cashier's check is now.

During an interview, the resident willingly met with the investigator. When the investigator explained what the investigation was about the resident's body language and facial expression changed. The resident shut down and refused to speak. The resident had a worried expression. At one point during the meeting, the resident gave a brief head nod, "yes" when asked if he wanted someone to continue looking into his financial concern but remained silent. During the meeting, only the resident and the investigator were present.

During an interview, the resident's family member said the resident gave the check to a "community leader" but he only knew the person's first name. He gave the investigator the "community leader's" phone number.

The "community leader's" phone number rang several times and went to voicemail. The investigator was unable to leave a voicemail as the voicemailbox was full. The "community leader" never returned the phone call.

In conclusion, the Minnesota Department of Health determined was inconclusive.

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: 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, declined interview.
Family/Responsible Party interviewed: Yes, he but declined a recorded interview.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
No known changes were made as the facility saw no issues with the incident and the resident no longer lived at the facility.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32758	A. BUILDING: _____ B. WING _____	C 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLNESS HOMES INC	4137 CHICAGO AVENUE MINNEAPOLIS, MN 55407

(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 On December 9, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL327585064C/#HL327586363M. No correction orders are issued.	0 000		