Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL339542480M
Compliance #: HL339548864C

Date Concluded: April 22, 2026

Name, Address, and County of Licensee Investigated:
Suite Living Senior Care of Roseville
197 County B2 W
Roseville, MN 55113
Ramsey County

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

Evaluator's Name: Lisa Coil, 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 the resident when the AP used the resident credit card to make unauthorized purchases following the death of the resident.

Investigative Findings and Conclusion: The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP admitted to using the residents debit card for personal purchases.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted other non-facility interviews: law enforcement and the resident's family member. The investigation included review of the resident record, personnel files, law enforcement documents, related facility policy and procedures.

The resident resided in an assisted living facility memory care unit. The resident's diagnoses included dementia and mental health conditions. The resident's service plan included assistance

with daily living activities. The resident's assessment indicated the resident was independent with managing her finances and was disorientated at times.

One day a concern arose when there were charges made to the residents debit card identified following the resident's passing away. The debit card was last known to be in the possession of the resident, as she was in charge of her own finances.

Law enforcement documentation indicated debit card purchases made on the day the resident date of death included Walgreens for $119.93, Speedway for $26.60, Doordash for $9.99. Additional purchases the day following the residents death included Speedway for $26.60, Target for $33.79, Amazon Prime $10.83, and a declined transaction at Target liquor for $99.74.

Durning an interview law enforcement stated they investigated a report of fraudulent use of the resident's debit card following the death of the resident. Law enforcement stated they received video surveillance during these purchases and were able to identify the AP. Law enforcement stated the AP admitted to using the resident's debit card for personal purchases. Law enforcement stated the AP was taken into custody.

During an interview, a family member stated the resident took care of her own finances, made her own purchases, and had a debit card in her possession while she lived at the facility. The family member stated they were unsure where the debit card was but the bank account has since been closed.

During an interview, a manager of the facility was unaware of the incident until she was notified by law enforcement. The manager was unaware of where the residents' debit card was following the incident.

During an interview, the AP stated the resident had given the AP her debit card a couple of weeks prior to her death to purchase some items for the resident. The AP stated she never returned the debit card to the resident prior to the resident's death and used it for personal purchases before and after the resident died. The AP stated she placed the debit card in a top dresser drawer in the residents room after using it. The AP stated she is going to court for the incident.

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
(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, is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: No action taken.

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 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
Ramsey County Attorney
Roseville City Attorney
Roseville Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33954	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING OF ROSEVILLE	197 COUNTY ROAD B2 WEST ROSEVILLE, MN 55113

(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: #HL339548864C / #HL339542480M On April 1, 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 19 residents receiving services under the provider ' s Comprehensive Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL339548864C / #HL339542480M, 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.	

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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 reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the an individual person was responsible for the maltreatment, in connection with incident which occurred at the facility. Please refer to the public maltreatment report for details.	02360		