Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL389813063M
Compliance #: HL389811757C

Date Concluded: August 6, 2026

Name, Address, and County of Licensee Investigated:
Freemont Village Senior Living
26369 2nd Street East
Zimmerman, MN 55398
Sherburne County

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

Evaluator's Name: Michele Larson, 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), an unlicensed caregiver, financially exploited two residents (resident #1, resident #2) when she stole money from them.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment for resident #1 and resident #2. On a hidden camera placed in resident #1's apartment the AP was observed stealing $740.00 cash from an envelope placed by law enforcement. The AP admitted to the theft. In addition, the AP admitted to stealing money from resident #1 multiple times and from resident #2 once; however, the amount of money the AP admitted she stole from them were inconsistent with the amounts reported missing by the residents. Additionally, during that time frame another resident reported $200.00 missing from his apartment but AP never admitted to stealing from that resident. Review of staff schedules showed the AP worked on the dates and during the time

periods when the residents reported their money missing. Furthermore, no further incidents of theft were reported after the AP was terminated.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family members. The AP was interviewed. The investigator reviewed the AP's employee file, facility incident reports, staff schedules, resident records, and related facility policy and procedures. The investigator reviewed resident #1 and resident #2's law enforcement report. The investigator observed resident and staff interactions while onsite at the facility.

Resident #1 resided in an assisted living facility. Resident #1's diagnoses included Parkinson's disease. Resident #1's service plan indicated resident #1 required daily assistance with dressing and weekly linen change every Sunday. Resident #1's assessment indicated he was alert and oriented, able to express needs and concerns, and able to recall and provide accurate information. Although resident #1 was able to report financial exploitation, he was susceptible to being abused by others. Resident #1 used a four-wheeled walker for mobility.

Resident #2 resided in an assisted living facility. Resident #2's diagnoses included anxiety and depression. Resident #2's service plan indicated she required assistance with showers every Tuesday and Saturday, and weekly linen change every Monday. Resident #2 was alert and oriented and was able to report financial exploitation but was unable to manage her own finances. Resident #2 used a four-wheeled walker for mobility.

Review of resident #1's police report indicated resident #1 reported he placed $800.00 cash in an envelope in his desk and two days later the cash was missing. Resident #1 reported a few weeks ago $400.00 was missing. Facility leadership noted the names of staff and the times they entered resident #1's apartment.

Review of the staff schedule indicated the AP worked the day resident #1 reported $800.00 cash went missing.

Review of resident #1's incident report indicated resident #1 reported $2,750.00 cash missing from a locked file cabinet located in a spare bedroom closet within his apartment. Review of facility camera footage recorded the AP was the only staff member who entered resident #1's apartment when resident #1 was not there and during the time frame when resident #1 reported the money missing. The facility encouraged resident #1 to continue to store his money in the locked file cabinet. The facility interviewed several unlicensed staff members, including the AP but no one admitted to taking resident #1's $2,750.00. The facility closed its investigation without identifying an AP. Resident #1 subsequently filed a police report.

Review of staff schedules indicated the AP worked during the time period resident #1 reported his money missing.

Review of resident #2's police report filed four months after resident #1 reported missing $2,750.00, resident #2 reported $330.00 missing from her purse. Resident #2 and her family member stated they consistently reported each incident of missing cash to facility leadership but stated leadership told them after every reported incident they reviewed camera footage and saw no staff enter resident #2's apartment when resident #2 was not there. Resident #2 told law enforcement a few days earlier, $65.00 cash missing from her purse after a staff member gave her a shower. Resident #2 told law enforcement staff stepped outside the bathroom and closed the bathroom door while resident #2 showered. When questioned by law enforcement on who resident #2 suspected stole her cash, resident #2 stated the AP's name.

Review facility staff schedules indicated the AP worked the same day resident #2's $65.00 went missing.

Review of resident #1's incident report indicated a few days after resident #2 filed a police report, law enforcement placed a surveillance camera and $1,000 cash in an envelope on top of resident #1's desk. The surveillance camera captured the AP stealing $740.00 from the envelope. The AP admitted to stealing the money and the facility terminated the AP.

When interviewed, facility leadership stated the facility did not send out any communication to the residents to inform them of reported thefts in the facility.

When interviewed, resident #1 stated money was stolen from him over a course of time. Resident #1 stated although some of his missing money was caught on camera and law enforcement caught the AP. Resident #1 stated they put the camera up a little too late. Resident #1 stated he had no more stolen money after the AP was caught.

When interviewed, resident #1's family member stated initially when resident #1 noticed money was missing, he never reported it. The family member when resident #1 reported missing $2,750.00, law enforcement told them resident #1 was not the only resident who reported money missing.

When interviewed, resident #2's family member stated a facility receptionist urged resident #2 to file a police report after resident #2 reported $65.00 cash was missing from her purse, stating the receptionist stated multiple residents reported missing cash. The family member stated resident #2 told her she had a shower the same day her $65.00 was stolen. The family member stated she told resident #2, "Whoever is giving you a shower is stealing your money." The family member stated leadership owed resident #2 an apology, stating they were aware of other residents reporting missing money yet did nothing to warn residents to protect their cash and valuables. The family member stated the incidents made resident #2 feel she was losing her mind and became more anxious each time more cash went missing from her purse.

When interviewed, the AP stated she stole from resident #1 “a few times,” and from resident #2, including another resident but was unsure of the exact amount. The AP stated she was a “terrible person” for committing the thefts.

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:
(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: Yes. Both resident #1 and resident #2 were interviewed.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The AP no longer is employed at the facility.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. 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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
Sherburne County Attorney
Zimmerman City Attorney
Sherburne County Sheriff's Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38981	A. BUILDING: _____ B. WING _____	C 06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREMONT VILLAGE SENIOR LIVING	26369 2ND STREET EAST ZIMMERMAN, MN 55398

(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: HL389814960C/HL389811000M HL389811757C/HL389813063M On June 8, 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 69 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL389814960C/HL389811000M, tag identification 2360. The following correction orders are issued for HL389811757C/HL389813063M, tag identification 630, 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.	
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure individual abuse prevention plans (IAPP) with specific interventions to address their new vulnerability of being financially exploited for three of three residents (R1, R2, R3) reviewed after an unlicensed personnel (ULP) stole money. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included Parkinson's disease and sensorineural hearing loss. R1's service plan dated November 6, 2025, indicated R1 required	0 630		

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0 630	Continued From page 2 daily assistance with dressing and weekly linen change every Sunday. R1 used a four-wheeled walker for mobility. R1's IAPP dated September 16, 2024, indicated R1 was able to manage his finances independently, able to report financial exploitation, and was susceptible to being abused by others. R1's Adverse Event Investigation dated December 4, 2025, at 12:03 p.m., and completed by licensed assisted living director (LALD)-E, indicated R1 reported $2,750.00 missing cash, stating on November 28, 2025, he went to the bank and withdrew $2,250.00 cash and placed the money inside a closet in a locked file cabinet located in his second bedroom in the same closet where R1's bed sheets were kept. R1 stated on December 1, 2025, he observed the $2,250.00 was missing along with an envelope containing $500.00 cash. R1's Adverse Event Investigation report dated April 16, 2026, at 12:30 p.m., on April 15, 2026, a sheriff county detective placed $1,000 and a camera inside R1's apartment. Camera footage revealed ULP-F stealing several hundred dollars from the $1,000 the detective placed in R1's apartment. ULP-F admitted to stealing the money. ULP-F was asked to immediately leave the premises. On April 17, 2026, ULP-F was terminated. R1's IAPP dated May 12, 2026, lacked documentation it was updated to include R1's new identified vulnerability to being financially exploited along with specific interventions to mitigate R1's risk of further financial exploitation.	0 630		

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0 630	Continued From page 3 R2 R2's diagnoses included depression and anxiety. R2's service plan dated June 6, 2024, indicated R2 required stand-by assistance with showers every Tuesday and Saturday, and linen changes every Monday. R2 was able to report financial exploitation. R2 used a four-wheeled walker for mobility. R2's IAPP dated February 22, 2024, indicated although R2 was unable to manage her own finances and was susceptible to being abused by others. R2's police report dated April 9, 2026, at 1:57 p.m., indicated family member (FM)-D and R2 reported $330.00 cash was stolen from R2 since the fall of October 2025. R2 stated she believed the money was stolen by a staff member while she took a shower since staff stepped outside the bathroom and closed the door while R2 showered. R2's Adverse Event Investigation dated April 19, 2026, at 8:28 a.m., indicated between April 6, 2026, and April 8, 2026, R2 reported $65.00 cash stolen from her purse. LALD-E encouraged R2 to keep R2's money in a locked cabinet in her apartment. R2's IAPP dated April 8, 2026, failed to indicate a history of reported stolen money. R2's IAPP lacked documentation it was updated to include R2's new identified vulnerability to being financially exploited along with specific interventions to mitigate R2's risk of further financial exploitation. R3 R3's diagnoses included degenerative joint	0 630		

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0 630	Continued From page 4 disease, osteoarthritis of the knee, and right hip fracture. R3's service plan dated September 30, 2025, indicated R3 received assistance with linen and laundry every Friday and daily medication administration. R3 used a four-wheeled walker for mobility. R3's IAPP dated March 1, 2025, indicated R3 was unable to manage his finances and required family assistance. R3 was able to report financial exploitation. R3's Family Grievance Form dated October 29, 2025, indicated FM-C reported someone went into R1's apartment and took $200.00 out of R3's locked money box inside a locked cabinet. Keys to the to the locked cabinet and box were hidden out of sight. R3's Adverse Event Investigation report dated October 30, 2025, at 2:45 p.m., R3 reported between October 24, 2025, and October 29, 2025, approximately $200.00 missing from his money box kept inside a kitchen drawer. Audio camera placed at the top of R1's refrigerator was not pointed towards the kitchen drawer where the locked money box was kept. R1's family removed all cash from R1's apartment. LALD-E encouraged R1 and FM-C to file a police report with the county sheriff's office. R3's IAPP dated June 10, 2026, failed to indicate a history of reported stolen money. R3's IAPP lacked documentation it was updated to include R3's new identified vulnerability to being financially exploited along with specific interventions to mitigate R3's risk of further financial exploitation. During an interview on June 8, 2026, at 1:00	0 630		

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0 630	Continued From page 5 p.m., registered nurse (RN)-A stated she performed change in condition assessments. The licensee policy titled Vulnerable Adult/Maltreatment-Communication, Prevention, and Reporting, dated October 2022, indicated residents would be continually assessed, care planned, and monitored in order to identify needs and behaviors which might lead to conflict or neglect. The facility would evaluate the individual's susceptibility of abuse and also evaluate the individual's risk of abusing other adults. The plan would also include the measures to be taken to protect that individual from abuse and to minimize the risk of abuse to other vulnerable adults. TIME PERIOD TO CORRECT: Seven (7) days.	0 630		
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 three of three residents (R1, R2, R4) reviewed were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and individual persons were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public	02360		

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02360	Continued From page 6 maltreatment report for details.	02360		