*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL296472323M
**Compliance #:** HL296474009C

**Date Concluded:** July 16, 2025

**Name, Address, and County of Licensee Investigated:**
The Waters of Edina
6300 Colonial Way
Edina, MN 55346
Hennepin County

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

**Evaluator's Name:**
Maerin Renee, 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 employee of the facility, financially exploited the resident. The AP received at least $99,000 in payments from the resident over the final 20 months of his life.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP developed a "special" relationship with the resident and enticed him to spend $1000-$2000 a month for personal care assistant (PCA) services outside the AP's work hours at the facility. In addition, the resident gave the AP three $25,000 checks for undisclosed reasons over the last six months of his life. The AP said she began to receive money from the resident on her birthday, and then on Christmas. The AP said she and the resident had a relationship no one else could understand.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family and law enforcement. The

investigation included review of the resident record, death record, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed resident interactions with staff.

The resident resided in an assisted living facility. The resident's diagnoses included cerebrovascular disease. The resident's services included housekeeping, laundry, and meals. The resident's assessment indicated he resident in independent living and did not receive assisted living services.

The facility's internal investigation indicated a family member sent an email to the facility informing them the AP received at least $99,000 in payments from the resident over the last 20 months of the resident's life. The family estimated payments began in 2023 but accelerated in the last eight months of the resident's life. The family member stated the AP had an unusually close relationship with the resident, as evidenced by communications the family reviewed, artifacts found while cleaning out the resident's apartment, and actions after the resident's death. Artifacts included numerous crafts and notes made by the AP expressing her admiration ("GOAT." sexiest man alive, etc.), and appreciation for all he did to "support" her in all aspects of her life. The family also reviewed text messages between the resident and AP but did not elaborate on details.

The family was aware the AP provided "care" in the form of checking in on the resident, being a Sunday caregiver including making occasional dinners, and taking the resident on drives, for which the resident paid the AP between $1000-$2000 a month. The family was also aware the AP had been "written up" (her words) for receiving payment from another resident. The family indicated they did not know how much money the resident gave the AP in the later months of the resident's life and after his spouse moved out to a memory care facility. The family was also unaware of the large checks ($25,000) the resident wrote to the AP.

The family member attached an itemized listing of the checks written to the AP, all cashed within three days of issuance. The resident wrote 19 checks to the AP over the course of nearly two years. Most of the checks were for $1000-$2000, but three checks were for $25,000.

The family member attached notes regarding conversations he had with the AP after the resident's death. The AP told him a staff member was "so mean" telling her that accepting money from an "old vulnerable man" was wrong. The staff member told the AP what she did was ethically and morally wrong. The AP said this staff member made her feel terrible. At that time the AP admitted to two $25,000 payments, and the family member clarified that it was three, and $99,000 total in payments. The AP started to say it wasn't that much, but the family member told her they had every check and her signature. The AP said she would give back what she could and if the facility found out she could lose her job, but the family member told her the point was that the AP accepted a significant amount of money from a vulnerable adult over the last six months of his life. The family member said he assumed the AP had received training

that accepting money from residents was wrong and the AP acknowledged receiving such training.

The family member went on to write approximately one month after the resident's death, the AP texted a family member about "inheriting" the resident's car. The AP felt the resident had "promised" her his car after he died. The family member told the AP the resident's will did not reflect that.

The internal investigation continued with an interview of the AP. The AP said she would run errands and have occasional dinners with the resident. The resident and AP would text each other or connect at the facility. The AP said she did not know how much money she received from the resident but started receiving money "a few years ago." The resident started on the AP's birthday, and then on Christmas. The AP said she understood she had an obligation to conduct business within guidelines that prohibited actual or potential conflicts of interest as well as not accepting gifts, but she did so anyway. The AP also acknowledged she had been coached on professional boundaries several times over her employment and that she had received training regarding boundaries and vulnerable adults. The AP went on to say she was bad with money and she and the resident had a relationship that no one else could understand.

The AP's training records indicated she received training in professional boundaries, outside employment, vulnerable adult statutes, and conflicts of interest. The AP's supervisor said she had multiple conversations with the AP about professional boundaries, which was also discussed in a performance review. A termination notice indicated the AP was released from employment by the facility due to accepting money from a resident on several occasions.

A police report indicated the resident's family member said the resident had a very close relationship with the AP. The resident did not have cognitive issues and lived independently at the facility. The resident had been writing monthly checks between $1000-$2000 to the AP for "care" the AP provided to the resident, outside of her work hours at the facility. The family was aware of this, saying the AP would check on the resident and provide companionship, make meals, take the resident on drives, including to the family's lake place. The AP also received at least three large payments from the resident of $25,000.00 each in July 2024, September 2024 and January 2025. The family member confronted the AP about these checks, and the AP said she was trained to not accept money from residents. The AP begged the family member not to inform the facility because she could lose her job. Approximately one month after the resident's death, the AP texted a family member regarding the resident's vehicle, which the AP said the resident promised her. The total amount of money sent to the AP was $99,000.

When interviewed, an administrator said she received an email from the resident's family member regarding thousands of dollars the AP had accepted from the resident, totaling almost $100,000. The facility was unaware the AP worked as a personal care attendant (PCA) for the resident outside of work hours. The family was more concerned about three payments of $25,000 each the resident gave to the AP during the final six months of his life, when he was on

hospice services. When interviewed, the AP said she knew it was wrong, she should not have accepted the money, she had received training about not being allowed to accept money and gifts, and she did it anyway. The administrator said the facility's policies prohibited staff from providing PCA services to residents. When asked about the $25,000 checks, the AP said she could not remember how much money the resident gave her and alluded that she had a special relationship with the resident. The first check the AP received from the resident was on her birthday a couple years prior and that is what started it. At the conclusion of the facility's investigation, the AP's employment was terminated.

When interviewed, a family member said after the resident's wife moved out, the AP began to dote on the resident and spend a significant amount of time with him. The family knew the resident was paying the AP $1000-$2000 a month for PCA services. After the resident died, the family member discovered in addition to the PCA payments, the resident had written three $25,000 checks to the AP, including one check ten days before the he died. The family member described the resident as a depression-era guy who always thought he was going to run out of money, so writing a check for $25,000 to someone was out of character. Approximately one month after the resident died, the AP called a family member to ask if she (the AP) had inherited the resident's car.

The family member said the AP never clarified the nature of her relationship with the resident, but the family member did read some text messages from the resident's phone. The AP texted the resident multiple times a day. Many messages were things like the AP missed the resident and needed to see him. The family member said while cleaning out the resident's apartment they found the AP had created a "sexiest man alive" People magazine cover of the resident, the AP's picture was on the resident's bulletin board, and there were signs of the AP everywhere in the resident's apartment.

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**: No, deceased.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: No, declined.

**Action taken by facility:**
The facility provided refresher training to staff regarding professional boundaries and accepting money and 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
Edina City Attorney
Edina Police Department

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 29647 | A. BUILDING: _____ B. WING _____ | C 06/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE WATERS OF EDINA | 6300 COLONIAL WAY EDINA, MN 55436 |

| (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<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL296474009C/#HL296472323M<br><br>On June 11, 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 146 residents receiving services under the provider's Assisted Living with Dementia Care license.<br><br>The following correction order is issued for #HL296474009C/#HL296472323M, 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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<br><br>Residents have the right to be free from physical, | 02360 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| 02360 | Continued From page 1<br>sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.<br><br>Findings include:<br><br>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.<br><br>Please refer to the public maltreatment report for details. | 02360 | | |