Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL379017042M
Compliance #: HL379016564C

Date Concluded: February 13, 2026

Name, Address, and County of Licensee Investigated:
Aspen Grove Alternative Senior Living
511 Iron Drive
Chisholm, MN 55719
St. Louis County

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

Evaluator's Name: Barbara Axness, 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 she used the resident's bank card over a period of nine months for her own personal use. Between unauthorized purchases and ATM withdrawals, the AP took almost $10,000 of the resident's money.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP had been given the resident's bank card to pay her rent. The resident was behind on her rent by several months. The AP admitted to the resident and facility management that she had made some accidental purchases on the resident's card after she was confronted by the resident and a case manager. After obtaining several past months bank statements, additional unauthorized purchases were discovered.

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

workers. The investigation included review of the resident record, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living memory care unit. The resident's diagnoses included post-traumatic stress disorder and anxiety. The resident's service plan included assistance with activities of daily living and medication administration. The resident's assessment indicated the resident's responsible party managed her finances.

Nine months of the resident's bank statements were reviewed. Eight months contained charges and ATM withdrawals that were not made by the resident. Charges were made at various retailers including WalMart, Domino's in a nearby city, Amazon, TikTok shop, Dairy Queen in a nearby city, and an online boutique. In total, $4,498.69 was charged to the resident's bank card. Multiple ATM withdrawals were made totaling $5,306. In total, $9,804 of unauthorized transactions were made from the resident's account.

A police report was not available as the investigation was still ongoing.

The facility's internal investigation indicated management was only aware of one month of unauthorized charges and were not aware of the other unauthorized charges over an eight-month period. The internal investigation determined the charges were accidental after the AP mistakenly stored the resident's bank card information on her online WalMart account after the AP claimed to have made an authorized purchase for the resident. Management reviewed the facility's related policies with the AP and verified the resident was paid back for the one month of charges they were aware of. Management told the AP she could no longer make purchases on behalf of other residents.

It was unable to be determined if the AP withdrew cash from ATMs however the resident reported to her case manager she hadn't withdrawn any money and wouldn't have been able to get to an ATM on her own. Facility records indicated the last time the resident paid rent was March 2025 when $840 was paid for statements from 2024. The resident had a past due balance of $6,712.

Two of the resident's case managers were interviewed. The case manager stated the resident called her after she received a bank statement after not seeing them for several months. The resident noticed several purchases that she did not make, and the case manager knew from her experience with the resident that she did not have the ability to shop online or get out to shop independently in the community. The case manager stated she and the resident met with the AP at the facility. The case manager stated they asked the AP about the charges and the AP tried changing the subject to the resident being behind on rent. The case manager stated at that time, they only had one month's bank statements and the AP stated she would pay the resident back. The case manager stated they decided to request the past several months statements and that was the first time they realized there were several thousand dollars worth

of unauthorized purchases and withdrawals made. The case manager stated the only month the resident had a bank statement delivered to her at the facility was the month the AP was on a leave of absence from the facility, otherwise the facility was supposed to be bringing her monthly statements. The case manager was not aware of the resident asking the AP to make purchases for her on her behalf.

A second case manager stated this fall she received a voicemail from the AP saying that she accidentally used the resident's bank card at WalMart for a few personal purchases and that she would pay the resident back. The case manager stated when she went to see the resident, there was $800 in cash and two cashier's checks in the resident's room that the AP had given her. The case manager stated the resident gave her bank card to the AP because the facility wouldn't charge her card for monthly rent, so the rent had to be paid in cash, and she thought the AP was paying her rent.

The AP declined to be interviewed and referred any questions to her attorney.

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:
(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: Unable, the resident passed away during the investigation

Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Declined

Action taken by facility:
The AP made a MAARC report related to one month's charges to the resident's bank card..
Facility management retrained the AP on vulnerable adult procedures and told the AP she couldn't assist facility residents with purchases.

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
St. Louis County Attorney
Chisholm City Attorney
Chisholm Police Department
St. Louis County Sheriff's Office
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37901	A. BUILDING: _____ B. WING _____	C 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ALTERNATIVE SENIOR	511 IRON DRIVE CHISHOLM, MN 55719

(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: #HL379016662C #HL379017042M/#HL379016564C On December 4, 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 27 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL379016662C, tag identification 0630, 1290. The following correction order is issued for #HL379017042M/#HL379016564C, 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.	
0 630 SS=D	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 update an individual abuse prevention plan which included statements of specific measures to be taken to minimize the risk of abuse to a resident who was a paid employee of the facility (R2). 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 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was hired on June 24, 2025, to work as an unlicensed personnel to do light housekeeping related work. R2's assessment dated September 12, 2025,	0 630		

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0 630	Continued From page 2 indicated the resident had self care deficit and history of mental illness. R2's assessment and individual abuse prevention plan (IAPP) lacked information on the resident being a paid employee of the facility and what steps would be taken to minimize risk of abuse to R2. On December 4, 2025, at 11:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-B stated R2 had worked as a paid employee for about six months and the resident would help with things like vacuuming. LALD/RN-B stated R2 wasn't on the schedule but she would just pick up shifts as she was able and willing to work. LALD/RN-B stated R2 was paid for her work and it gave her a sense of purpose and something to focus on. On December 4, 2025, at 12:20 p.m., R2 stated she worked as a paid employee for the facility as a kitchen helper and she would do dishes, pass juices, pour coffee, help pick up, and vacuum. On December 15, 2025, at 12:26 p.m., clinical nurse supervisor (CNS)-A confirmed R2's IAPP lacked an assessment of R2 being a paid employee of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 630		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section	01290		

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01290	Continued From page 3 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was current, affiliated, and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) with the assisted living license for one of one employees reviewed (R2). This had the potential to affect all residents residing in the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to ensure R2 had a current and eligible background study.	01290		

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01290	Continued From page 4 R2 was hired on June 24, 2025, to work as an unlicensed personnel to do light housekeeping related work. An employee record for R2 was requested on December 4, 2025, but was not immediately available. NETStudy Roster indicated R2's background study was initiated on December 4, 2025. On December 12, 2025, a background study was provided for R2. The clearance letter was dated December 10, 2025, and indicated more time was needed to complete R2's background study. As of December 22, 2025, R2's background study was still in process. On December 4, 2025, at 11:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-B stated R2 had worked as a paid employee for about six months and the resident would help with things like vacuuming. LALD/RN-B stated R2 wasn't on the schedule but she would just pick up shifts as she was able and willing to work. LALD/RN-B stated R2 was paid for her work and it gave her a sense of purpose and something to focus on. LALD/RN-B stated R2 might have an employee record in the kitchen. On December 4, 2025, at 12:20 p.m., R2 stated she worked as a paid employee for the facility as a kitchen helper and she would do dishes, pass juices, pour coffee, help pick up, and vacuum. R2 stated she enjoyed the job and was paid hourly for her work. R2 stated she had some training and was comfortable doing the work. The licensee's Background Studies policy dated	01290		

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01290	Continued From page 5 March 5, 2025, indicated the facility would conduct a background study on all employees, volunteers, and contractors. No employee would provide direct services and have independent direct contact with any residents until acceptable results of the background study had been received. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	01290		
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, 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	No plan of correction required for this tag.	